

Nebraska's Professional Partner Program

Individualized Care for Youth with Serious Emotional and Behavioral
Disorders and their Families

Annual Report 2001

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



Department of Services • Department of Rehabilitation and Learning • Department of Family and Support

NEBRASKA'S **PROFESSIONAL PARTNER PROGRAMS**

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December, 2001

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NEBRASKA'S PROFESSIONAL PARTNER PROGRAM

December, 2001

Dear Friends:

I want to take this opportunity to introduce to you Nebraska's Professional Partner Program! Nebraska is fortunate to be one of the leaders in the effort to provide quality, home based services to families. Through a wraparound approach, many children and families in Nebraska who are in trouble, are able to get the support they need to keep their families together.

Nebraska's Professional Partner Program offers a unique approach to serving families. The wraparound approach involves not only the family, but neighbors, schools, churches, law enforcement, service agencies, and communities, in finding out what it takes to make the family stronger. When families break apart, the cause often has a simple solution. This solution, however, may not be available or known to the family. If families can learn to draw upon available resources to solve their problems successfully, in the future more serious problems can be avoided. If children can stay with their families in times of trouble, the result is not only a cost savings on out-of-home care, but a family that feels more secure with the confidence that they can work things out together.

Professional Partners help to coordinate services around the family, assist them in becoming stronger, and offer tools to help them cope with their struggles. The family learns the necessary skills to continue to work out their problems on their own, to listen to each other, and have a community support system to fall back on when it seems they are all alone.

Since 1996, the Professional Partner Program has seen remarkable progress in the youth and families it serves. The number of families served per year has almost tripled since the Program's inception, with a total of 761 families participating this year alone. I am very excited about the success of the Professional Partner Program and the future it helps build for Nebraska's families.

The following report describes the history and objectives of the program, and provides data to support it's success. I invite you to read the next few pages to learn more about this innovative program. I also invite you to become involved in families – your own and others – as we seek to build stronger families and communities in Nebraska.

Respectfully,

Ron Ross
Director of the Department of Health and Human Services

SUMMARY

During the summer of 1994, Nebraska's Governor hosted a Child and Family Mental Health Search Conference. The impetus of the conference was that mental health service systems were fragmented and unconnected, and policy development was conflicting and uncoordinated. Seventy key leaders were brought together for the purpose of developing a shared commitment to build an integrated system to promote the provision of high quality, seamless, mental health services for children and families.

Participants identified the following as being crucial for an integrated system of care:

- ❖ A clear point of access to services 24-hours a day, 7 days a week;
- ❖ A Professional Partner to assist families in navigating the system;
- ❖ A single, coordinated assessment addressing multiple agency requirements;
- ❖ Flexible funding, not tied to specific service categories, but used for creative services and supports unique to each child and family's needs;
- ❖ Regional Human Service Districts that integrate mental health, child welfare, juvenile justice, and education which blend and jointly administer funds; and
- ❖ Outcome-based accountability.

From these key components the Nebraska Professional Partner Program was developed, serving Nebraska families who have children or adolescents needing mental health services.

Professional Partner Programs are located in each of Nebraska's six Mental Health Regions.

The philosophy of the Professional Partner Program is to be strength-based, family-centered, and acknowledge families as equal partners. The Program provides a flexible, individualized approach that promotes utilization of the least restrictive, least intrusive developmentally appropriate interventions in accordance with the strengths and needs of the youth. The purpose of the Program is to improve the lives of children with serious emotional disturbances and their families. The mission of the Program is to use the wraparound approach to coordinate services and supports to these families and to ensure they have a voice, ownership, and access to a comprehensive, individualized support plan. Without the Professional Partner involvement, many of these children would enter residential programs at a much higher cost.

At the heart of the Program is a service coordinator, referred to as a *Professional Partner*, who works in partnership with each youth and his or her family entering the Professional Partner Program. The Partner, as a part of the child and family team, assists the family with obtaining a comprehensive assessment, developing an Individual Family Support Plan (IFSP), purchasing both traditional services and flexible supports identified in the IFSP, and monitoring the outcomes. The Professional Partner has a small caseload (no more than 15) which allows them to give each family the time they need. Currently there are approximately 65 Professional Partners in the state.

Funds became available July 1, 1995, and the Program has served 1,476 families since its inception. Outcomes indicate children and families are satisfied with the services they receive, feel included in the planning efforts, and believe they are doing better as a result of the Program. Data also indicates a significant level of improvement in the youth's functioning during service in the Professional Partner Program.

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Description of Nebraska's Professional Partner Program

NEBRASKA'S PROFESSIONAL PARTNER PROGRAM

Purpose --- Philosophy --- Mission



The *purpose* of the **Nebraska Professional Partner Program** is to improve the lives of Nebraska's children with serious emotional/behavioral problems and their families.



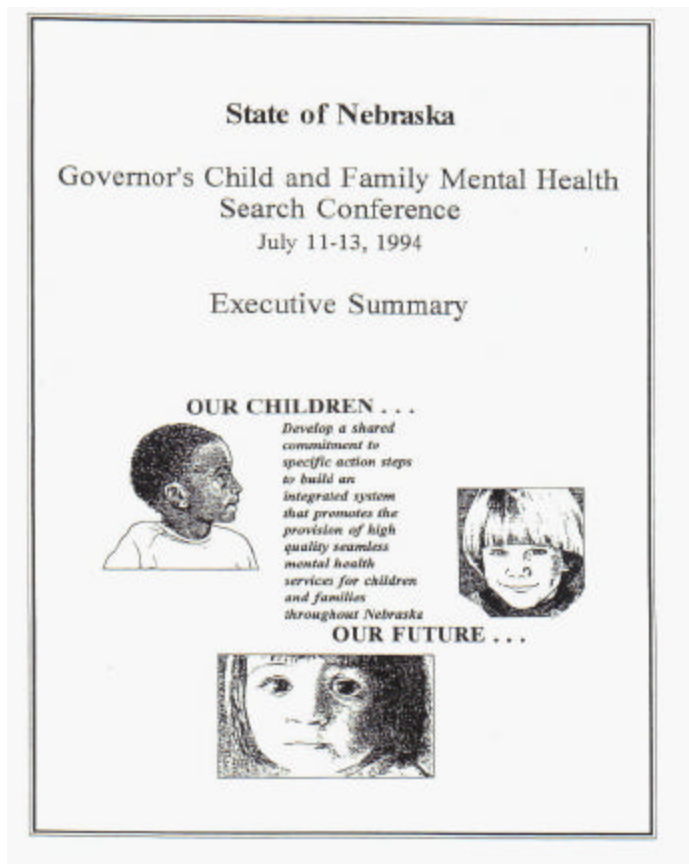
The *philosophy* of the **Professional Partner Program** is to be strength-based, family-centered, and acknowledge families as equal partners. The Program provides a flexible, individualized approach that promotes utilization of the least restrictive, least intrusive developmentally appropriate interventions in accordance with the strengths and needs of the youth. The mix, intensity, duration and location of services and supports are individually tailored to meet the unique needs of each youth and his or her family. A Professional Partner helps ensure the services are culturally competent, community based, and involve natural community supports.



The *mission* of the **Professional Partner Program** is to use the wraparound approach to coordinate services and supports to families who have children with serious emotional/behavioral problems and to ensure they have a voice, ownership and access to a comprehensive, individualized support plan.

SEARCH CONFERENCE IS THE CATALYST FOR AN INTEGRATED SYSTEM OF CARE FOR NEBRASKA'S CHILDREN AND FAMILIES.....

During the summer of 1994, Nebraska's Governor hosted a Child and Family Mental Health Search Conference. The impetus of the conference was that mental health service systems were fragmented and unconnected, and policy development was conflicting and uncoordinated. Seventy key leaders were brought together for the purpose of developing a shared commitment to specific action steps to build an integrated system that promotes the provision of high-quality, seamless, mental health services for children and families in Nebraska.



Key leaders were brought together for the purpose of developing a shared commitment to specific action steps to build an integrated system that promotes the provision of high-quality, seamless mental health services for children and families in Nebraska.

This broad-based participatory process included representatives from the following:

- ❑ Parents (about 1/4 of the participants were parents)
- ❑ Providers, both public and private
- ❑ Mental Health Regional Administrators
- ❑ Educators
- ❑ Probation
- ❑ Law enforcement and County Attorneys
- ❑ Advocacy Agencies
- ❑ Private Insurance
- ❑ Legislature
- ❑ Universities
- ❑ Professionals, including psychiatry, psychology, social work, and nursing
- ❑ State Agencies, including Public Institutions, Social Services, Juvenile Services, Health, Education, Foster Care Review Board and the Crime Commission

Participants identified the following key components as being crucial for an integrated system of care:

- ❖ A clear point of access to services 24-hours a day, 7 days a week;
- ❖ A *Professional Partner* to assist families in navigating the system;
- ❖ A single, coordinated assessment addressing multiple agency requirements;
- ❖ Flexible funding, not tied to specific service categories, but used for creative services and supports unique to each child and family's needs;
- ❖ Regional Human Service Districts that integrate mental health, child welfare, juvenile justice, and education which blend and jointly administer funds; and
- ❖ Outcome-based accountability.

From these key components, the **Professional Partner Program** was developed. The components serve as the framework for serving Nebraska families who have children or adolescents needing mental health services.

THE NEBRASKA LEGISLATURE SEES NEED FOR “FRONT-END” AND FLEXIBLE FUNDING FOR CHILDREN’S MENTAL HEALTH.....

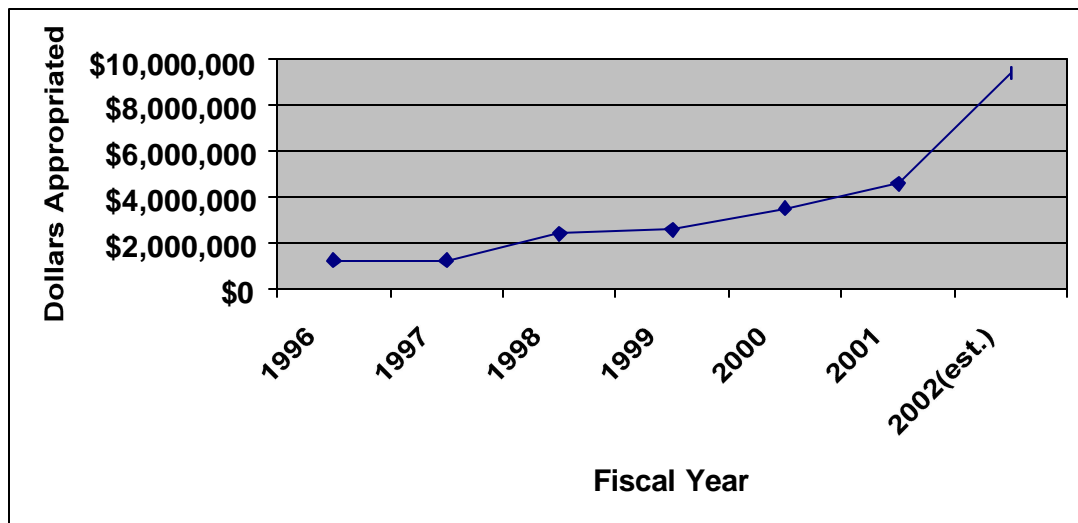
The Beginning of the Professional Partner Program.....

Prior to the implementation of the **Professional Partner Program**, little state funding was dedicated to children’s mental health. In 1995 the Governor’s Budget Initiative included \$600,000 for children’s mental health services. The Governor proposed two pilot sites for the initial **Professional Partner Program**. In that same year, the Legislature instead increased that amount, and appropriated \$1,212,500 for a statewide program with the following objectives:

- To provide mental health services for youth not Medicaid eligible but who were at risk of becoming state wards to access services; and
- To distribute funds equitably to each of the state’s six Mental Health Regions to fund mental health services for children.

The funds became available July 1,1995. Professional Partners were hired in October and by spring of 1996, Professional Partners were serving full caseloads.

Figure 1. Funding of the Professional Partner Program and Care Coordination by Fiscal Year



The Professional Partner Program Expands.....

The 1997 Legislature appropriated a \$676,500 increase to the Program, allowing the Professional Partner Program to serve state wards and Medicaid eligible youth. The expanded funding allowed the **Professional Partner Program** to serve an additional 97 youth statewide that were at high risk of being placed out-of-home, committing a juvenile offense, or dropping out of school. In FY 2002, rate increases enhanced funding to a total of \$2,037,555.

Recent Initiatives Bolster the Professional Partner Program.....

In October 1997 Nebraska received a grant (\$8,500,000 over 6 years) from the Federal Center for Mental Health Services to develop a comprehensive system of care for children in 22 counties in Central Nebraska. The purpose of the project, entitled Nebraska Family Central, parallels many of the Professional Partner objectives:

- Develop an array of effective services provided by highly trained staff,
- Provide individualized care and coordination of services through a wraparound approach,
- Ensure parents are equal partners at all levels
- Ensure service provision and system design are culturally competent
- Integrate the service delivery system across mental health, education, child welfare, juvenile justice, and substance abuse through a community-state partnership, and
- Effectively manage the system to produce positive outcomes for children and families in a cost-effective manner.

Grant funding programs have steadily increased for wraparound in Region III. In addition to the Professional Partner Program, the Project provides funding for school-based wraparound team and community wraparound teams. Estimated funding for wraparound in Region III for FY 2002 is \$1,184,186. Additionally, Region III and the Department of Health and Human Services have entered into an agreement to serve 201 high need youth in the Protection and Safety system through the wraparound process. The cost of this initiative is approximately \$5,153,310 annually.

Grant funding expanded the Professional Partner Program and middle intensity services for the targeted areas.

In May 1998 a pilot project integrated 20 youth into the community from Youth Rehabilitation and Treatment Centers. Through a collaborative effort between children's behavioral health and the Protection and Safety Division within the Department of Health and Human Services, programs were developed in two areas of the state (Central and Southeast) to prevent juvenile offenders from entering the youth rehabilitation and treatment centers (i.e., state juvenile detention facilities). These two programs employ a combination of:

- Wraparound through the Professional Partner Program
- Multi-systemic Therapy which provides an ecological approach to address issues within the family, school, community, and peer groups, and
- Accountability through graduated sanctions (e.g., electronic monitoring, reporting centers, rewards, curfews) based on behavior.

Nebraska's Health and Human Services, Protection and Safety provided \$200,000 to fund the two pilot sites. Each pilot is capable of serving 10 youth at a time. The Professional Partner Program has continued to expand its partnership with Protection and Safety.

In August 1998, Nebraska received a second grant from the Federal Center for Mental Health Services to focus on youth involved in the juvenile justice system in Lincoln and Lancaster County. This program, Families First and Foremost (see page 16 for more information), also parallels **Professional Partner Program's** objectives. The grant is administered through Lancaster County: Families First and Foremost. The funding, \$8,500,000 over a six-year period, seeks to:

- Develop a community-controlled comprehensive service delivery system that build on the strengths of individuals, citizen associations, and local child-serving and funding agencies;
- Ensure that families of youth with serious emotional disturbances are full partners in all aspects of the system of care including governance, service delivery, advocacy, and evaluation;
- Develop an array of services that are comprehensive, individualized, culturally competent, and offered in the youth's natural environment (home, school, community), and
- Establish an evaluation and continuous quality improvement process that will shape future system/program direction using empirically-based best practice models of service delivery.

This grant funding expanded Care Coordination in the Lincoln and Lancaster County area by \$652,700 annually. In FY 2001, the project expanded wraparound to cultural centers located throughout the county.



Nebraska received a small increase in Federal Block Grant Funds for FY 2001. Of the funding, \$83,850 was targeted to develop a rural school wraparound program for 10 youth and their families. Region I successfully applied for this funding and developed a joint program with Chadron Public Schools (see page 24 for more information). A second school wraparound program is scheduled to be funded in FY2002.

WHO DO WE SERVE?

Referrals to the **Professional Partner Program** come from probation, schools, social services, county attorneys, mental health service providers, families, and neighbors.

Nebraska's **Professional Partner Program** is targeted for children and youth with serious emotional disturbances (as defined below), who have very high needs. Without Professional Partner involvement, many of these children would enter residential programs at a much higher cost. To be eligible for the program, children must be at high risk for one or more of the following:

- out-of-home placement;
- becoming a state ward to access services as a result of inadequate family financial resources or potential child abuse or neglect;
- committing a juvenile offense; or
- dropping out of school.

During Fiscal Year 2001, the average length of time a youth was involved in the program was 12.52 months.

Following is the definition of serious emotional disturbance used by the Professional Partner Program:

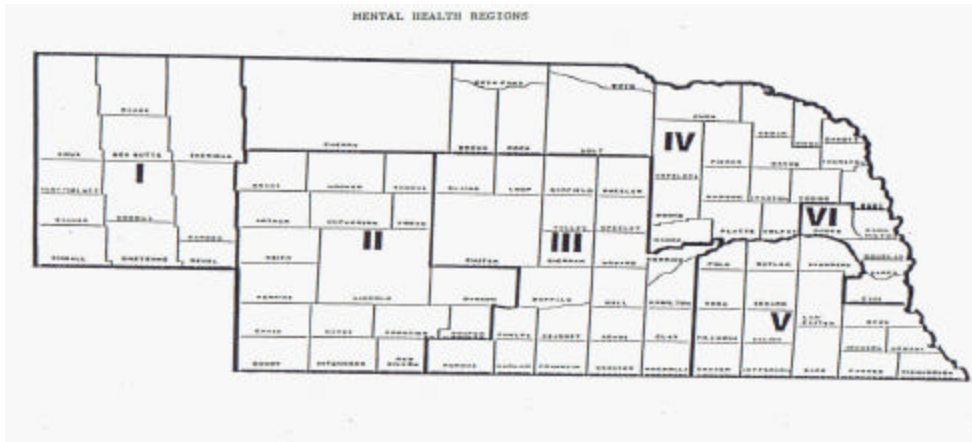
- 1) The youth must be 18 years old or younger. However, for transition into adult services, the youth may be up to age 20.
- 2) The youth must have a mental illness diagnosable under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
- 3) The condition must be persistent in that it has existed for one year or longer, or is likely to endure for one year or longer.
- 4) The mental illness must result in the functional impairment of the youth in two or more areas, as measured by the Child and Adolescent Functional Assessment Scale (CAFAS).

The CAFAS measures functioning in the following areas:

- **Role Performance**
 - School/Work
 - Home
 - Community
- **Behavior Towards Others**
- **Moods/Self Harm**
 - Moods/Emotions
 - Self-Harmful Behavior
- **Substance Use**
- **Thinking**

ORGANIZATIONAL STRUCTURE AND ADMINISTRATION OF THE PROFESSIONAL PARTNER PROGRAM

The State of Nebraska is divided into six (6) Behavioral Health Regions to administer and provide mental health and substance abuse services to children and adults. The Department of Health and Human Services administers contracts and provides funding to each of these six regions. **Professional Partner Programs** are located in each of Nebraska's six Behavioral Health Regions.



Professional Partner Programs

Region I Professional Partner Program
Contact: Nick Thelen
Panhandle Mental Health Center
4110 Avenue D Scottsbluff, NE 69361
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Region II Professional Partner Program
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Region III Professional Partner Program
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(308) 237-5113

Region IV Professional Partner Program
Contact: Deb McCoy
206 Monroe Avenue Norfolk, NE 68701
(402) 370-3100

Region V Professional Partner Program
Contact: C.J. Johnson
1645 "N" Street Suite A Lincoln, NE 68508
(402) 474-6055

Region VI Professional Partner Program
Contact: Beth Sparks
3801 Harney Street, 2nd Floor; Omaha, NE 68131-3811
1941 S. 42nd Street Omaha, NE 68105
(402) 444-6573 or 6540

The Programs vary in their administrative structure, but each offers administrative, clinical, and fiscal supervision.

At the heart of the Program is a service coordinator, referred to as a *Professional Partner*, who works in full partnership with each youth and his or her family entering the **Professional Partner Program**. The *Professional Partner*, as a part of the child and family team, assists the family with obtaining a comprehensive assessment, developing an Individual Family Support Plan (IFSP), purchasing both formal and informal services identified in the IFSP, and monitoring the outcomes of these services and supports. The *Professional Partner* has a small caseload (no more than 15) which allows the Professional Partner to give each family the time they need. Currently there are approximately 55 Professional Partners in the state.

Nebraska's Professional Partners and Staff as of 12/1/01

Region I

Nick Thelen, Director
Bridget Trebilcock, Professional Partner
Rachel Delle, Professional Partner
Pamela Rogers, School Based Prof. Partner
Becky Slunecka, Family Advocate for
Western Community Health Resources
Cris Laue, Family Advocate Supervisor

Region II

Corrie Edwards, Supervisor
Joette Diaz, Director of Supportive Svcs.

Region III

Dave Hoyt, Wraparound Training Specialist
Jill Schubauer, Supervisor
Terri Keller, Intake/Referral Coordinator
Jen Puls, Professional Partner Program Asst.
Andrew Brackett, Professional Partner
Melissa Craig, Professional Partner
Troy Jardine, Professional Partner
Felipe Cruz, Professional Partner
Tara Wilson, Professional Partner
Laurie Lee, Professional Partner
Angie Marquardt, Professional Partner
Dwain Fowler, Professional Partner
Sara Christensen, Co-located School-Based PP
Monte Kyes, School-Based Team
Harriet Lambrecht, School-Based Team



Region IV

Deb McCoy, Director
Tonja Asmus, Administrative Assistant
Beth Stealey, Intake Coordinator
Susan Nathan, Professional Partner
Stacie Haiar, Professional Partner
Carrie Henke, Professional Partner
Jenise Crosby, Professional

Region V

C.J. Johnson, Director of Network Services/FYI
Missy Davis-Schmit, Assistant Program Director
Malcom Miles, Assistant Program Director
Leah Yetter, Professional Partner
Micheal Miller, Professional Partner
Shelly Noerrlinger, Professional Partner
Jon Kruse, Professional Partner
Sara Foust, Professional Partner
Kristin Nelson, Professional Partner
Khari Wallace, Professional Partner
Amanda Tyerman, Professional Partner

Region VI

Beth Sparks, Program Manager
Paul Yakel, Clinical Supervisor
Becki Coleman, PP Lead Worker
Debbie Richardson, Professional Partner
Hanneka Brown, Professional Partner
Shane Bruns, Professional Partner
Pete Myhr, Professional Partner
Brandi Bibbins, Professional Partner
Judy Hassler, Professional Partner
Lisa Tompsett, Professional Partner
Marla Jenkins, Professional Partner
Andria Copple, Professional Partner
Susan Wood, Professional Partner

The Wraparound Approach Gains Popularity with Other Organizations

Since the inception of the Professional Partnership Program, several organizations have started using the wraparound approach to provide services to the youth of Nebraska. One of the primary goals of the Professional Partnership Program was to promote the use of wraparound and to facilitate its use in Nebraska. The organizations listed here are programs in Nebraska that the Professional Partner Program recognizes as providing wraparound services. Throughout this report, information concerning funding, outcomes, and relationship with the Professional Partnership Program are available for some of these programs.

Families CARE

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Toll free (Family line): 1-877-225-0500
Fax: 308-23-7669
Email: familiescare@region3.net

Suzanne Young, Executive Director
Jodi Studnick, Family Coordinator
Monica Sleicher, Family Evaluator
LaDonna Wieczoreck, Family Care Partner
Brenda Fletcher, Youth Coordinator

Community Teams

Contact: Elaine Pflepson
308-237-5113

Integrated Care Coordination

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Supervisor – Kearney & Hastings
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Hastings, NE 68901-2005
308-865-5568
Fax: 402-462-1870
Or
Bernie Hascall
Supervisor, Grand Island & Ord
PO Box 2440
Grand Island, NE 68802-2440
308-385-6169
Fax: 308-385-6173

Hastings: Cheryl Gentert, Case Aide; Karen Anderson; Piper Hermann; Jeannene Olson; Kelly Jensen
Kearney: Marilyn Reilly, Case Aide; Stephanie Anderson, Case Aide; Ricke Moses; Deb Stone-Haga; Keri Russell; Danielle Redman; Sarah Nicholson; Kelly Madden; Jay Dunning; Barb Estes

Grand Island: Andrea Rodriguez, Case Aide; Chad Gressley; Broc Arehart; Taunya Steele; Kristy Borgheiinck; Gretchen Heuftle; Megan LeBeau; Dayna Barker; Sara Nelson
Ord: Cindy Miller

Families First and Foremost

Contact: Nyla Helge
315 S. 9th St. Ste 200 Lincoln, NE 68508
(402) 441-4870

Nyla Helge, Director

Indian Community Center:

Mary Lee Johns, Care Coordinator Supervisor

Tina Mesa, Care Coordinator

Hispanic Community Center:

Rev. Dr. Joel Gajardo, Care Coordinator Supervisor

Nicole Miller, Care Coordinator

Clyde Malone Community Center:

Jerry Buss, Care Coordinator Supervisor

William Bryant, Care Coordinator

Renee Massie, Care Coordinator

CF Star:

Brian Miller, Care Coordinator Supervisor

Jody Busse, Care Coordinator

Asian Community and Cultural Center:

Maria Vu, Care Coordinator Supervisor

Holly Le, Care Coordinator

Good Neighbor Community Center:

Rita Chen-Brown, Care Coordinator Supervisor

Sarah Nelson, Care Coordinator

Carol Yoakum Family Resource Center:

Barb Dewey, Care Coordinator Supervisor

Carmela Sanchez-Casados, Care Coordinator Supervisor

Jenny Hill, Care Coordinator

Faces of the Middle East: Lincoln Interfaith Council:

Rev. Dr. Norm Leach, Care Coordinator Supervisor

Zainab Al-Baaj, Care Coordinator

Zainab Al-Albatat, Care Coordinator

Sief Mahagoub, Care Coordinator

Lincoln Public Schools:

Dr. Becky Wild

PROGRAM DESCRIPTION

The **Professional Partner Program** followed the guidelines established at the 1994 Governor's Search Conference to develop the Program Description. Overarching themes create the framework of the Program:

- ❖ *Family Centered Philosophy*
- ❖ *Flexible Approach*
- ❖ *Community Based - Coordination of Assessment*
- ❖ *Wraparound Approach*
- ❖ *Interagency System of Care*
- ❖ *Flexible Funding*



"The Professional Partner Program is not just another service or program, but is the best process of effectively serving children with severe emotional disabilities and their families:"

Mark DeKraai, Children's Mental Health Administrator, HHS

Family Centered Philosophy

With all the people I have worked with in the past, I have never met one that felt as strongly as my Professional Partner does about the strength of a family. That is why this program is so successful in our area, by believing in families as the primary resource.
—A Parent

The Professional Partner Program embraces a *family-centered philosophy* and acknowledges families as equal partners. This philosophy promotes the least restrictive, least intrusive developmentally appropriate interventions in accordance with the youth and family needs within the most normalized environment.

Families are involved at all levels of decision making. Families are key decision-makers throughout the eligibility, assessment, and service development processes, and are the co-leaders of a multi-disciplinary team responsible for developing a plan for the family.

Our Professional Partner is so involved with us it's like she is part of our family.
— A Parent

Flexible Approach.....

Operating within a “*whatever it takes*” approach to service planning, the multi-disciplinary team develops an Individual Family Service Plan (IFSP). The IFSP addresses the unique needs of the youth, while maximizing the extent to which the expertise and wisdom of family members are taken into account.

The **Professional Partner Program** ensures the availability of an accountable individual - a *Professional Partner* – to coordinate the services identified in the IFSP. This *Professional Partner* works in partnership with the family to help keep the youth in the home, in school and out of jail. The *Professional Partner* serves as an advocate, service broker, and liaison on behalf of the youth and his or her family for the purposes of:

- linking and accessing needed services
- bringing together the child and family team to coordinate service components and all phases of treatment and support
- ensuring that the elements of treatment and supportive services are planned for and provided



The
Professional
Partner Program
embraces the
philosophy of
unconditional care:

**No Reject,
No Eject**

I would like to introduce you to a very special person in my life. That special someone is my 15 year-old son, John. John is a boy every mother dreams of claiming as her own...he's polite, cleans up after himself, gets himself up to an alarm, does his own laundry, meets your gaze with clear eyes and answers your questions honestly. He speaks to his elderly grandfather in a gentle, loud voice, and plays with small children with a sincere enthusiasm that can't be faked. He does well in school and is willing to spend a quiet night alone with adults, talking about a variety of subjects, such as books he's read or plans for his future. He never fails to show his gratitude for even the smallest thing with smiles and hugs and thank-you's. Pretty special young man, right? Right. The most remarkable fact is that 6 months ago this same young man was extremely defiant and ended up running away due to an overwhelming addiction to marijuana and emotional problems. In addition to his marijuana addiction, John was diagnosed with Oppositional Defiant Disorder and Adjustment Disorder with mixed conduct. His life involved wearing a leg monitor to watch his every moment, court appointments nearly every month, weekly therapy, and a fractured relationship with his father.. His friends were, to a number, illegal drug users and dealers, he was failing 9th grade, and many of the adults in his life had nearly given up on him. How did this young man undergo such a dramatic transformation? With the help of God, a substance abuse treatment center, and a young staff member of Professional Partners. During the months that followed, the Professional Partner became my right arm. She has, within the structure of Professional Partners, been able to offer mentoring and tutoring, transportation and court representation...invaluable services to persons desperate for help. She spent countless hours on the phone in the role of liaison between several professionals and the treatment center. Professional Partners is a remarkable program, with valuable services for individuals such as my son and myself. But a program is only as good as its employees and my son is a success story because of our Professional Partner and her co-workers' dedication, commitment and professionalism.

Community Based-Coordination of Assessment.....

The **Professional Partner Program** combines an **ecological assessment and treatment planning approach** with wraparound services and intensive therapeutic case management. Children and adolescents targeted for the Program often have needs across many areas, such as education, juvenile justice, child welfare, substance abuse, and developmental disabilities. Therefore, the Professional Partner must collaborate within and across other child serving systems in their community.

During the eligibility process, the family is centrally involved in defining the problems and needs associated with their child's emotional disorder, as well as defining their own needs. The **assessment process** begins with the identification of the youth's and family's strengths rather than their problems and identifies resources, concerns and priorities across twelve (12) life domains. These life domains include:

Mental health	Cultural	Family	Vocational
Social/Recreational	Residential	Medical	Education
Substance Abuse	Safety	Legal	Financial

Wraparound Services.....

“Wraparound is a community process-not a program. The community must embrace the family/youth”. John VandenBerg

The essential elements of the wraparound process include:

No Reject, No Eject Policy

Youth are not selected to fit a pre-existing program; rather, the program adapts to meet the needs of the youth. Youth are accepted regardless of the complexities of their behavior characteristics or histories and are never terminated because of the challenging nature of their needs.

Strength-Based Assessments

Interventions and strategies capitalize on the strengths or assets of the youth, family and community.

Holistic Approach

The strategies and interventions are focused on life domain areas such as family, living situation, financial, educational/vocational, social/recreational, behavioral/emotional, psychological, health, legal, cultural, and safety, which are prioritized by the youth and family.

Individualized Care Planning

An Individual/Family Support Plan is developed by a team that includes the youth, family members, professionals, and concerned individuals from the community. The strategies in the plan are unique to the needs of the individual and are limited only by the creativity of the team.

Use of Informal Community Resources

The wraparound approach focuses on delivering services and supports within the youth's natural environment such as the home and school, and accesses available community resources as a means of stepping down from formal services.

I am very glad that I have received all of the help that we have. Before the program I had problems getting help. I even had problems getting my own family to understand what is going on with my child. Now that I have worked with the program, I have seen and felt that there are people who understand and care about my family and me. – A Parent

The **Professional Partner Program** utilizes specific methods for moving toward an *interagency system of care* by developing referral sources, collaborative working relationships, and integration and coordination with families and public and private child serving systems. The mix, intensity, duration and location of services and supports are individually tailored to meet the unique needs of each youth and his or her family.

This program has been a savior for the school system. Through them we have put together a team that has been able to support and maintain this child in the classroom. Our Professional Partner makes herself available to the family and the professionals at any time. She works very hard to come up with options when options seem to no longer have an effect on behaviors.

As the Family/School Liaison at a school, I have been very fortunate to be able to utilize the services that the Professional Partners Program offers. An important aspect of my position is to be able to refer students and their families to services that will meet their physical, social and emotional needs. As a smaller community, the resources that we have here are extremely limited. Professional Partners has been able to provide many of our families with support and resources that would otherwise be inaccessible to them. As a referral source, I have found the referral process to be simple and non-threatening to clients. Susan Woods has done a wonderful job of making quick contact with our families in need of services, as well as keeping me updated on the status of the referral. I have also served on a number of Treatment Teams in the program. I have been impressed with the comprehensive assessment that is completed on each family, which focuses not only on needs, but also on family strengths. Also helpful are the concrete goals that address each area of need, as well as addressing who is responsible in seeing that each goal is met. Overall, my involvement with the Professional Partners Program has been very positive. It is a service that is essential in our community. Through this program, we are able to provide for the emotional needs of the children and families that are seeking our assistance.

The Professional Partner Program operates with a ***flexible funding*** approach. The services and supports that can be purchased are individualized and not limited to traditional mental health interventions; they are focused on producing positive outcomes. Funding for the Professional Partner Program incorporates a combination of checks and balances.

Components of the flexible funding components include:

Case Rate Reimbursement

Services are reimbursed on a case rate basis of \$698.00 per child per month. Funding is flexible and follows the child and family as their needs change.

Individual and Family Support Plan (IFSP) Authorization

The Professional Partner Program supports the fact that the child and family team knows best what services should be authorized. The only restriction is the creativity of the IFSP team. The key issue is how the expenditures will meet the outcomes identified. The needs are met by services and supports.

Professional Partners are able to develop and purchase creative, individualized, services and supports as identified in the IFSP. The services are flexible, not categorical, and focus on producing outcomes. The Professional Partner ensures the use of community-based services and natural supports whenever possible.

Checks and Balances

Each program has a process to monitor their budget and control costs. Program Directors monitor the expenditures by child and across all cases. A monthly financial report is submitted to the Department. The reports are aggregated by child and clearly show how the funds are serving the youth in the system. Sometimes families receive donated items or services. Public funds in the Professional Partner System only cover those services not covered by private insurance or other funding sources.

Reinvestment of Savings

Each of Nebraska's six Mental Health Regions is allocated a number of children/adolescents to be served at any point in time and appropriated a case rate per child/adolescent. The number of children varies from region to region. If average expenditures per child/adolescent fall below the case rate the remaining funds are used to improve the Professional Partner Program and increase the number of youth and families served.

COMPONENTS OF THE PROFESSIONAL PARTNER PROGRAM

- ❖ A Family-centered philosophy and working with families as equal partners. This approach includes providing the majority of professional partner services in the natural environment of the youth and family (e.g., home, school) rather than in the professional partner's office
- ❖ Access to services is based on need and there is a clear, single point of access to services 24 hours per day, 7 days per week
- ❖ A “no reject, no eject” approach of unconditional care to eligible youth. Youth with extremely difficult behaviors shall not be terminated or excluded based upon difficult behaviors
- ❖ Meaningful involvement of parents, family members and consumers in advisory and policy development capacities
- ❖ Coordinated, interagency collaboration for assessment, referral, and service plan development, including an Individual and Family Service Plan (IFSP)
- ❖ Purchase and development of creative and individualized services and supports identified in the IFSP
- ❖ A Professional Partner to lead the coordination of services, with a small client load that ranges from 10-15 so the Partner can spend adequate amounts of time with each family
- ❖ Culturally competent and gender sensitive policies and processes
- ❖ The least restrictive, least intrusive, developmentally appropriate intervention in accordance with the youth and family needs within the most normalized environment
- ❖ Specific methods for moving toward an interagency system of care by developing referral sources, collaborative working relationships, and integration and coordination with families and public and private systems serving youth with emotional disorders such as schools, social services, probation, courts, law enforcement, developmental disability services, health providers, youth shelters and substance abuse services
- ❖ Maintained within an organization which does not provide any other mental health services, if possible, to enable an independent choice of service provider
- ❖ Flexible funds which follow the child and family, including traditional and non-traditional community-based services and support based on a case rate
- ❖ Measurable outcomes
- ❖ A public information strategy to inform others on how to access the Professional Partner system

NEW APPROACHES

Integration with Multisystemic Therapy

The Nebraska model is an ecological approach incorporating wraparound and multisystemic therapy (MST). It is a collaborative model based upon a thorough understanding of both the wraparound process and MST by all staff and community members involved with the family. Wraparound is the primary intervention used by the Professional Partner Program, with MST being utilized on a selected basis as a specialized clinical treatment for specific families.

MST is a family and community-based treatment using an ecological approach for youth with complex clinical, social and educational problems. Generally, the target population to receive MST services include youth: 1) ages 10-20, 2) diagnosed with a DSM-IV mental health disorder, 3) placed out-of-home or at risk of an out-of-home placement, 4) involved in the juvenile justice system or at-risk of committing a criminal offense, and 5) experiencing school failure, or at-risk of dropping out or being expelled from school due to behavior problems. Also, the youth's parents or caregivers must be willing to participate in the program in a partnership role.

The goals of MST treatment are to:

- ◆ Eliminate or greatly reduce the frequency and intensity of the youth's referral behavior
- ◆ Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents and to empower youth to cope with family, peer, school and neighborhood problems
- ◆ From the first meeting the therapist is planning for discharge by establishing clear criteria for success and by facilitating interventions that are carried out, as much as possible, by family members and other support within the community

The focus of multisystemic therapy is on producing behavior change in the natural environment of the youth/family. The service delivery mechanism is an intensive Family Preservation model that emphasizes working with the multiple systems that impact the youth including the youth him or herself, family, peers, school, community, and other child-serving agencies. The goal is to make permanent changes in these systems that will endure after service delivery. The average length of service is four months, and each MST Therapist has a caseload of 4-6 families. Each MST Therapist works as part of a clinical team that is available to the family 24 hours per day, 7 days per week.

Region III is using this approach and contracting with South Central Behavioral Services and Mid Plains Center for Behavioral Health Services in Central Nebraska.. Both agencies have experience in providing Intensive Family Preservation Services and have been trained in Multisystemic Therapy. These agencies receive weekly consultation from Multisystemic Therapy, Inc. from South Carolina.

School-Based Wraparound.....

A major issue with many wraparound-planning efforts involves the intersection of the community, social service providers, and the schools. One of the most difficult problems is engaging school personnel to become full partners in the wraparound process. Developing a school-based support plan, as part of an overall wraparound plan is often complex due to language and system barriers between schools and other child and family team members. The wraparound approach must include improved academic performance as well as behavioral functioning for children.

In the Region III Professional Partner Program, an educational facilitator teacher or school personnel teams with a family facilitator (Professional Partner) and the Child and Family Team to coordinate the school plan. Planning efforts around the child and family create an environment in which the school is an integral part of the overall assessment and support for the child and his/her family. This *School-Based Wraparound Approach* allows the teacher and/or other school personnel to feel comfortable voicing classroom based concerns (academic and behavioral) and members of the Child and Family Team are also able to understand these concerns. The two individuals work closely together as a team to assist and coordinate services to a combined caseload of approximately 20 children/families. Both individuals bring specific strengths to the team from their varied backgrounds in the school and in the community.

As a result, issues of control and compliance are resolved and teachers feel they have support with challenging students. Teachers and other school personnel are aware of what will happen next, have a chance to voice concerns, and are given the opportunity to add to the strengths assessment of the student. The school and social community both feel a commitment to the overall wraparound process.

The School-Based Program in Region I's Chadron School District is currently providing services to 11 youth and their families. After a very successful first year, the program has seen a reduction in trancies and an increase in school performance. The program gives priority to families and/or schools in need of enhanced collaboration between the two parties. Also, to students who demonstrate significant school impairments as evidenced by academic failures, behavior challenges in the school setting and truancy.

Pamela Rogers continues to do an excellent job coordinating services for the youth with special needs. She currently is employed by Region I and shares office space at the Panhandle Mental Health Centers office in Chadron. Shirley Edwards, principal of Kenwood elementary school and special education director, provides the educational expertise for the program. Shirley tends to know just about everything about her student's and their families. She has been an incredible asset for the School-Based Program.

The goals of the program are to eliminate or greatly reduce the frequency and intensity of the youth's referral behavior, empower parent's with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school and community issues. The program also strives to develop a network of informal supports to help sustain the child and family when formal services are no longer needed. Finally, utilizing the wraparound approach, the program hopes to reduce negative consequences for the child including out-of-home placements, juvenile justice involvement, and school failure, while enhancing positive outcomes including improved school performance and successful transition to adult living and employment.

Integrated Care Coordination Unit.....

The Integrated Care Coordination Unit is a joint project of the Department of Health and Human Services and Region III Behavioral Health. The initiative is intended to provide an individualized system of care to 201 state wards with the highest needs and their families. The children and adolescents targeted by this program have high functional impairment in multiple areas, are involved with multiple agencies, have persistent, long-term problems, and have the highest service costs in the state. In fact, the targeted 201 youth constitute less than 25% of the state ward population in Central Nebraska, but they account for almost 70% of the resources used. In addition, the youth selected to receive these services are those who have shown poor outcomes with traditional services. Accountability for outcomes is an important aspect of the Professional Partner Program, as it is in this initiative. This project has resulted in reductions in the number of out-of-home placements, juvenile offending and length of stay in the system, as well as improvements in educational attendance and performance, youth behavioral functioning, and youth and family satisfaction with their services. The program also intends to maintain public safety, expand the array of community services and decrease the use of inappropriate, high-cost residential services. In 2000, more than \$5 million was spent on these 200 children. Using 95% of this funding and a wraparound approach, this integration has expanded the services available to these high-need, high-cost youth to meet their individual needs and improve their outcomes, thereby reducing current and future costs to the State of Nebraska for residential care. The project includes co-location, cross training, and joint supervision of Region III and HHS staff.

Co-location with Protection and Safety.....

Region III Professional Partner Program is successfully completing its third year of an agreement with Nebraska Department of Health and Human Services to serve 10 OJS youth. The goals are to continually increase collaborative efforts, as well as to further understand the function of each agency. A Professional Partner completed the Health and Human Services 16-week training for Protection and Safety Workers. This Professional Partner was educated on Health and Human Services state mandates and policy and procedures, and participated in all certifications relevant to PSW and OJS.

Part of the responsibilities of the Professional Partner is to attend Health and Human Services weekly staff meetings, as well as intake and referral meetings. The Professional Partner carries a full case load of 10 OJS clients. In addition, the Partner is supported by Region III through attendance of staff meetings, staff development, and training sessions.

Co-location with Other Agencies.....

In previous years, Region V has had up to nine Professional Partners co-located with other agencies. Two had been co-located with Lincoln Public Schools and have since become employees of the Lincoln Public School System demonstrating how the school system has found the services they provide to be invaluable. Region V previously had two Professional Partners co-located with Blue Valley Mental Health; as of January 1, 2002, this position will be maintained by one person, covering seven counties in Nebraska. Another co-located Professional Partner worked with Tom Osborne's Teammates Mentoring Program. This position will end on December 31, 2001. The final four co-located Professional Partner positions, two with Health and Human Services and two with Juvenile Probation, are no longer maintained. The caseloads for these nine Professional Partners were made up of referrals from their designated co-located agencies.

Lancaster County Care Coordination Project.....

Families First and Foremost is a project funded by a federal grant to establish a comprehensive system of care in Lancaster County of mental health and other support services. The intent is to organize a coordinated network to meet the complex and changing needs of children and adolescents with serious emotional disturbances and their families. The target population of their project is youth with serious emotional and behavioral disorders in or at risk of being involved in the juvenile justice system. As one component in the system of care, Families First and Foremost has contracted with several community-based agencies to provide care coordination using the wraparound philosophy. Eleven Care Coordinators are employed and housed at the following agencies in Lincoln: the Indian Community Center, Hispanic Community Center, Good Neighbor Community center, Carol Yoakum Community Center, Faces of the Middle East and Northeast High School. With care coordination located in the community-based agencies, Families First and Foremost will strive to assure that the wraparound process will be community-based and culturally competent to serve the needs of youth and families in Lancaster County.

Community Wraparound.....

In Region III, funding has been awarded to Community Teams to provide early wraparound services and supports for children and families who are at high risk to enter into the mental health, child welfare, juvenile justice, and education systems. This early intervention approach is coordinated and administered by a broad-based community team made up of child-serving agencies, family members and community representatives. The community team oversees a Wraparound Facilitation Team which consists of core members of the community team who have been trained in the wraparound process and agree to be wraparound facilitators. The Wraparound Facilitators volunteer their time but have access to flexible funding and an array of services and supports. The Wraparound Facilitators direct the child and family teams to meet the stated needs using the strengths the youth and family possess. A particular valuable resource in these teams is the help that families are given to access informal community supports. This process promotes the concept of communities taking care of its children and their families, as it truly takes a community to raise a child.

PROFESSIONAL PARTNER PROGRAM: WINNING AWARDS FOR QUALITY

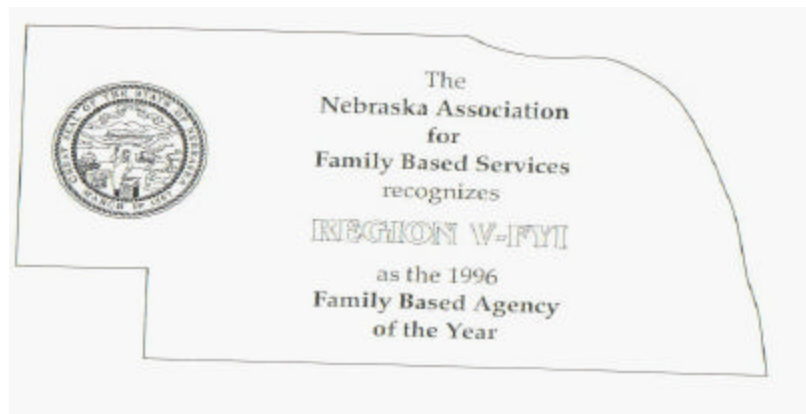
Region III was awarded *accreditation from CARF* in 2001 for professionally approved standards and practices. This designation provides information and guidance to the public regarding service provision that meets CARF standards.

Region IV's Professional Partner Program was featured twice on radio talk shows and cited in several newspaper articles regarding the services available through the organization in 2001.

Corrie Edwards, the director of the Region II OMNI Professional partner Program was recognized with the *Making A Difference Award* in 2001 by the Federation of Families for Children's Mental Health . The award is given to recognize a professional *who works with, or on behalf of, children of adolescents with mental health issues and their families.*

Region V of the Professional Partner Program was recognized twice in 2000 for their efforts with children and families in Nebraska. They received *Honorable Mention for the Thomas M. Wernert Award for Innovation in Community Behavioral Healthcare*, and a *three-year accreditation from CARF* for Psychosocial Rehabilitation Programs, including Intensive Family Based Services.

In 1996, Region V was recognized as the Family Based Agency of the Year by the Nebraska Association for Family Based Services.



In August, 1999 Corrie Edwards from Region II was awarded the Advocate of the Year Award from the RITES for Families. Christy Fricke, the director of RITES for Families, wrote that several parents who were in attendance when the award was presented spoke of the heartfelt gratitude they have for Ms. Edwards and the OMNI Professional Partner Program for helping their family when no one else could or would.

EVALUATING THE PROFESSIONAL PARTNER PROGRAM:

DOES THE PROGRAM REALLY WORK? ARE CHILDREN AND FAMILIES DOING BETTER?

Nebraska's Professional Partner Program is continually evaluated to help inform decision makers at the state, regional and individual practice level on how a comprehensive model of service delivery can effectively reduce youth violence and keep youth in school, with their families, and in their communities.

An evaluation plan has been designed to investigate the effects of the Professional Partner Program in preventing youth from becoming state wards to access services, and reducing out-of-home placements, juvenile crime, and school failure.

The Professional Partner evaluation focuses on the following:

- ☐ Who are We Serving?
- ☐ What Services are They Receiving?
- ☐ At What Cost?
- ☐ What are the Outcomes?

Several tools and assessments are utilized to collect data and to "paint a picture" of the Professional Partner Program. A complete presentation of the data can be found in the Data Presentation- Appendix, which is available upon request from the Department of Health and Human Services.

Josh was referred to the Professional Partner Program by his school in late April. The school referred Josh because of his disruptive behaviors in school, poor grades and because of a recent protection order that was placed against him by a peer. The professional partner was able to facilitate a team meeting at the school with all of Josh's teachers shortly after acceptance into the program. Josh was able to hear the positives of his ability academically and athletically. Josh was also able to hear the concerns that the teachers had regarding his performance in school. The team was able to meet again before school was let out for the summer to discuss what Josh would need to work on before returning next year. The teachers agreed to provide study materials and the professional partner assisted in providing a tutor that would meet with Josh on a weekly basis. The tutor and Josh met weekly during the summer working on the study materials. The tutor also served as a mentor with Josh to work on appropriate social skills. When school resumed in the fall another team meeting was held at the school with his teachers for the upcoming school year. A plan was devised that the teachers would be able to have weekly contact with the tutor on any concerns or areas in need of work by writing a note and leaving it in the guidance counselor's mailbox where the tutor would pick up the note. The team decided to stop services through the professional partner program by the second semester of school due to significant improvement in Josh's grades and behaviors. By the second semester Josh's grades were all passing and above average. Josh and his family were also able to arrange continuing services with the tutor which had been provided by the Professional Partner Program, even though services with the Program had been discontinued.

WHO ARE WE SERVING?.....

The Professional Partner Program has grown substantially over the last five years. During FY01, the Program served 761 children and adolescents statewide. Since inception 1,476 of Nebraska's youth and families have received services from the Professional Partner Program.

Table 1. Number of Children Served By Year

Year	FY97	FY98	FY99	FY00	FY01
Number of Children Served	223	365	477	665	761

Table 2. Number of Children Served By Region

	Region 1*	Region 2	Region 3	Region 4	Region 5	Region 6	Total
FY 01	33	25	233	79	194	197	761
Since Inception	62	57	399	191	304	463	1,476

*This includes 11 youth from the Chadron School Program.

The mean length of stay for youth in the Professional Partner Program varies by region. However, the overall average time in the program across regions was 12.52 months during FY01.

Table 3. Mean Length of Stay in Program (in Months)

	Region 1*	Region 2	Region 3	Region 4	Region 5	Region 6	State Average
Average Time in PPP	11.5	16.24	10.51	11.93	13	13	12.52

*This includes youth involved in the Chadron School-Based Program in Region 1.

Referrals come from a variety of sources. The following table shows several of these referral sources by Region.

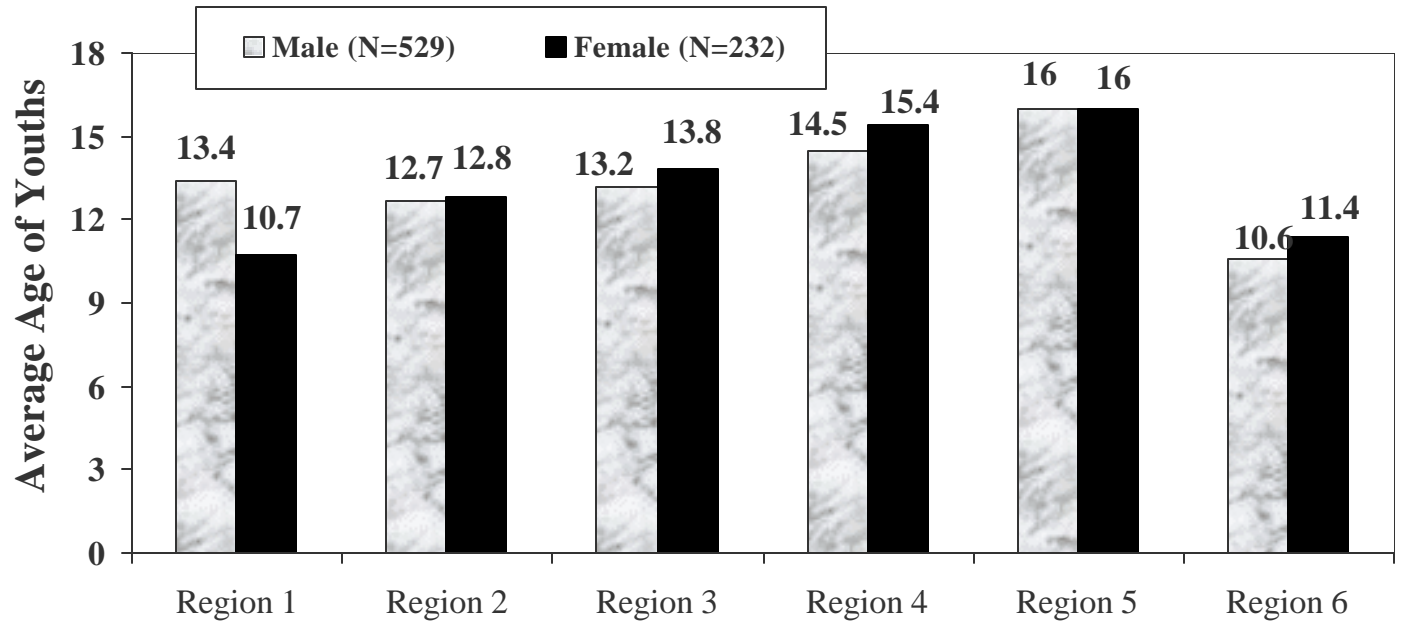
Table 4. Percentages of Youth by Referral Source for each Region 3

	Region 1*	Region 2	Region 3	Region 4	Region 5	Region 6
Health & Human Services (including Child Welfare/CPS)	3.03	8	11.6	10.1	9.27	7.61
OJS	-	-	-	7.59	23.2	1.02
Probation	3.03	-	-	3.79	14.4	5.58
Mental Health Agency/Providers	24.2	32	32.6	21.5	11.7	5.08
Schools/ESU	45.4	12	29.2	22.8	19.0	59.9
Friends/Family/Guardian/Self	15.2	36	8.15	20.	7.73	8.12
Inpatient Program/Hospital	-	4	1.7	-	2.06	0.51
Community Agency	9.09	8	-	8.86	55.8	8.12
Court	-	-	1.7	3.00	-	-
Attorney	-	-	-	5.06	-	-
Other	-	-	10.7	-	5.67	-

* These include the 11 youth from the school based program in Region 1 who all had "school" as their referral source.

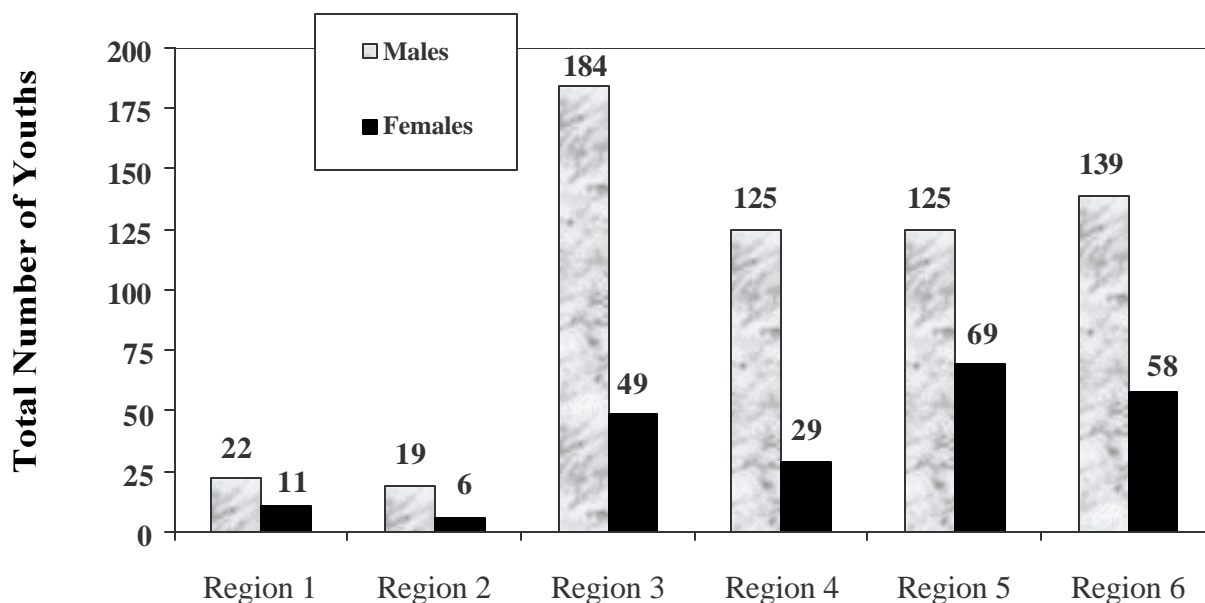
The average age of all children and adolescents served in FY01 is 13.18 years.

Figure 1. Average Age of Youth in Each Region by Gender for FY01



Overall, the Professional Partner Program served significantly more males than females during FY01 (Males = 529, Females = 232), although the differences vary somewhat by region.

Figure 2. Total Number of Youths in Each Region by Gender for FY01

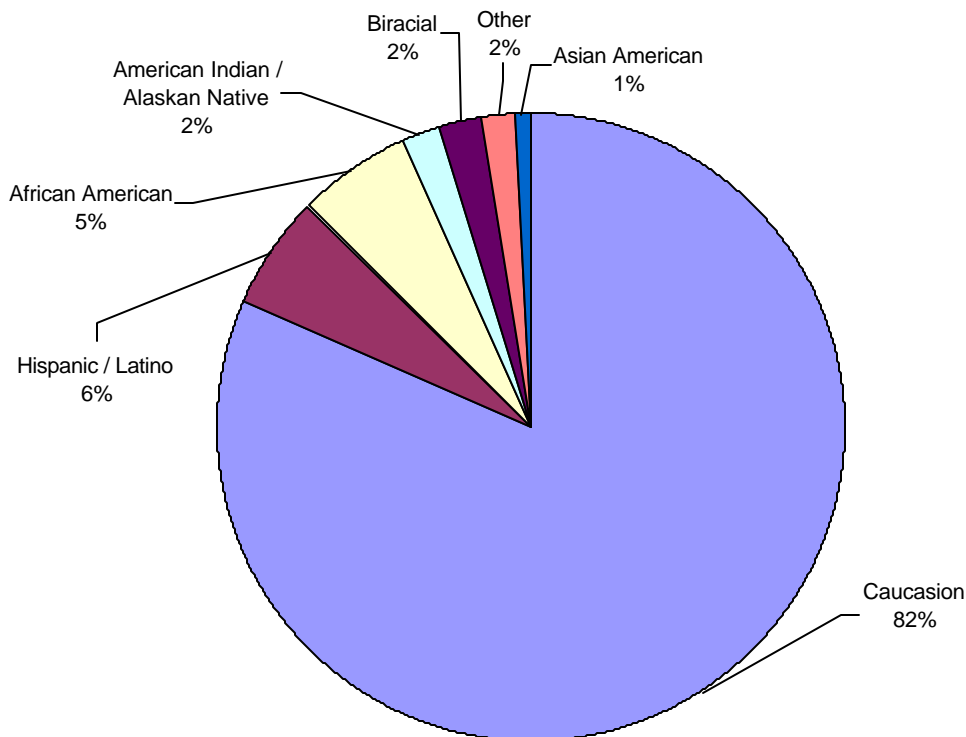


Race & Ethnicity

The majority of children in the Professional Partner Program during FY01 were Caucasian (82%) although several other racial and ethnic groups were represented among those receiving services (5%-African American, 6%-Hispanic, 2%-American Indian/Alaskan Native, 1%-Asian American, and 2%-Biracial).

According to 2000 estimates from the U.S. Bureau of the Census, these percentages correspond very closely with the racial/ethnic breakdown of Nebraska's youth population. Nebraska residents under the age of 18 are 85.13% Caucasian, 5.37% African American, 8.27% Hispanic/Latino, 1.32% Native American/Alaska native, 1.9% Asian, and , .05% Hawaiian/Pacific Islander).

Figure 3. Percentage of Youths Served by Race/Ethnicity for FY01 (N=937*)

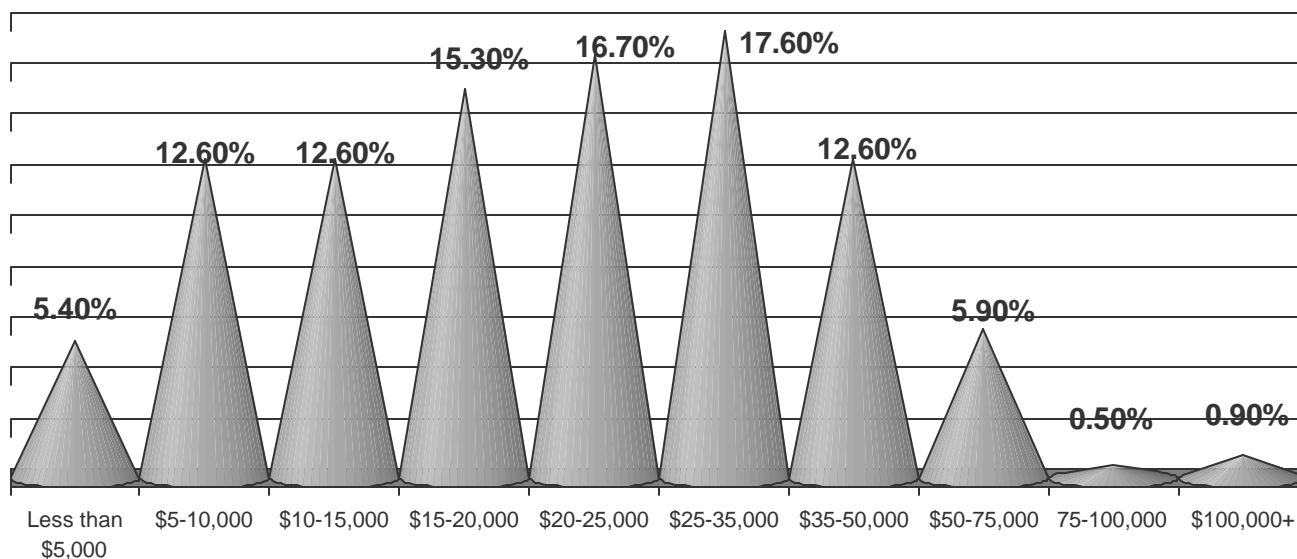


*The Total N is greater than the number of children served during FY01 indicating that many youth entered multiple race/ethnicity categorizations therefore alluding to a higher percentage of biracial youth in the program than are indicated here.

Household Income

The families entering services tend to fall in lower income ranges. The poverty rate in the United States varies by the number of children and by whether the home is a single versus two-parent home. However, for a four-member household, the poverty threshold in 2000 was \$17,050. In Region III, the distribution indicates that over one third of the families served have income ranges below this poverty level.

Figure 4. Gross Household Income of Families Entering Services –Region III



The average gross income for families in Regions 2 and 4 were \$26,042 and \$23,071, respectively.

Presenting Issues

Children and adolescents entering the program have a variety of presenting issues. The following are the most frequent across Regions I, II, III, IV and V:

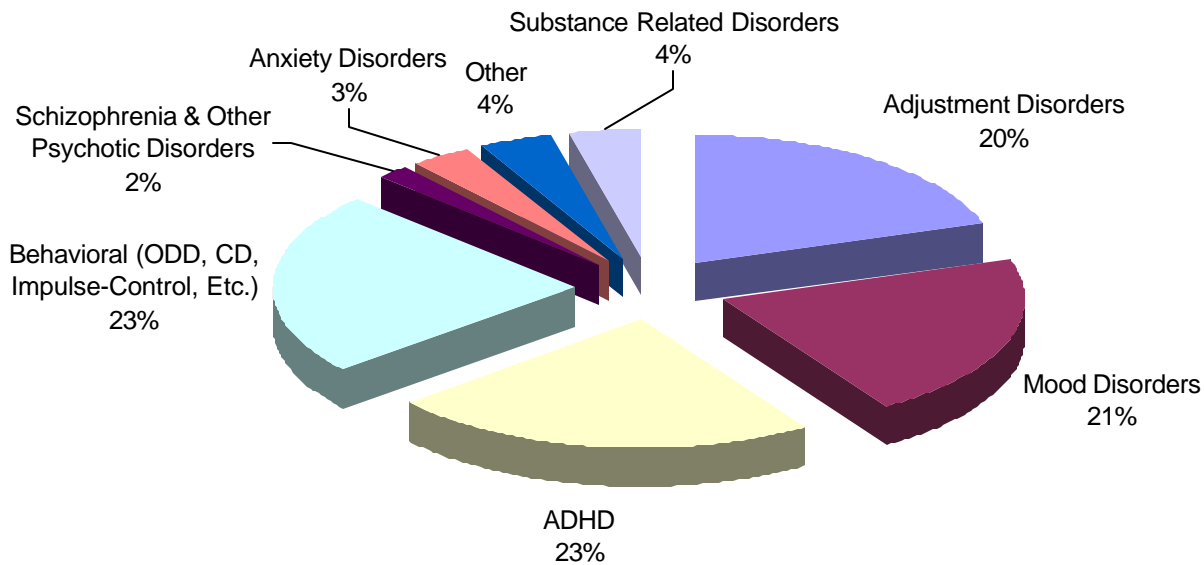
Depression
Substance Abuse
Attention Deficit/Hyperactivity
Non-Compliance
Antisocial/Illegal Acts/Criminal Activity

Physical Aggression
Anxiety
Property Damage/Theft
Poor Peer Interactions
Academic Problems/Truancy
Need for Community Services

Diagnosis

To be eligible for services, all youth served by the Professional Partner Program are required to have a DSM-IV diagnosis. Children in the Program have many different psychiatric diagnoses. The primary diagnoses that the youths presented with during FY01 are presented below. The majority of the youth had two or more co-morbid disorders when they were referred to the program.

Figure 5. Diagnosis at Intake for all Regions for FY01 (N=835)*



*Many youths had multiple diagnoses.

As noted above, many youth in the program have multiple diagnoses. Regions 1, 2, 4, & 5 reported the number of youth in their programs with two or more DSM-IV Axis I diagnoses. Overall, more than half of the youth, 58%, in these regions presented with comorbidity.

Youth Risk Factors

Region I, II, and III reported that youth in those regions had the following risk factors:

- 40.6% History of Substance Abuse (Alcohol, Tobacco, or other drugs)
- 31.8% Physically Abused
- 30.9% Previous Run Away
- 25.5% Previous Psychiatric Hospitalization
- 23.0% Sexually Abused
- 14.1% Attempted Suicide
- 13.4% Have Been Sexually Abusive to Others

The Families First and Foremost program (for more information see page 16) also reported risk factors for the youth in their program during their final quarter of FY01. Fifty-four percent of the youth had more than one of the following risk factors:

- 45% Previous Psychiatric Hospitalization
- 48% Previous Run Away
- 33% History of Substance Abuse
- 30% Physically Abused
- 20% Sexually Abused
- 21% Attempted Suicide
- 10% Have Been Sexually Abusive to Others

Region III reported risk factors for youth in the program that are associated with their biological family. Over half of the youth report a family history of substance abuse and of violence in the family. Nearly half have a family history of mental illness.

- 55.8% History of violence or spousal abuse in the family
- 47.7% History of mental illness in the family
- 34.5% History of mental illness have had a parent in a psychiatric hospital
- 46.8% Biological parent who has been convicted of a crime
- 65.1% History of substance abuse among biological family members
- 49.3% History of substance abuse in the family have a biological parent who has received treatment for substance abuse

Educational disruptions

Based upon caregiver reports on the Educational Questionnaire (Region III, FY99)

- ☛ At intake, all 54 children had attended school in the past six months
- ☛ 41.5% of 53 youth had been suspended from school in the previous six months
- ☛ 45.3% of 53 youth had been sent to detention at least once in the previous 6 months
- ☛ 8.1% of 37 youth had been expelled in the past 6 months

Region III investigated the educational attainment of children in their program. They found that 2% were receiving a grade average of an "A", 21% of "B", 30% of "C" and 13% of lower than a "C". In addition, 11% reported that they were failing half of their classes while another 23% reporting all or most of their classes. These data are for FY99.

Figure 6. Educational Attainment of Children in Region III at Intake (FY99)

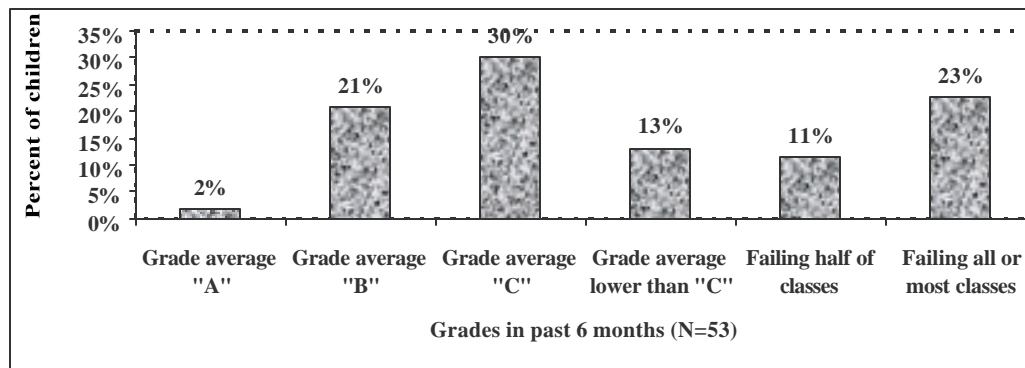
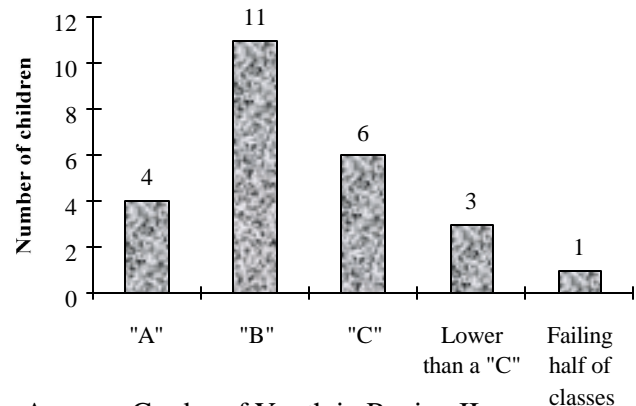
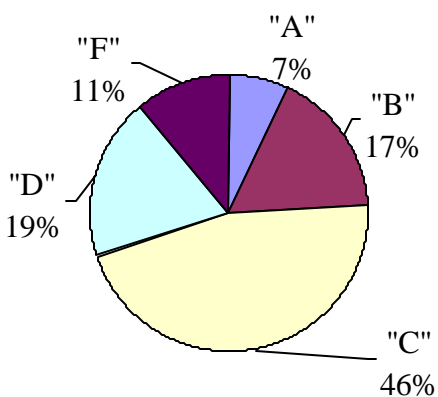


Figure 7a & b. Educational Attainment in Region II & IV at Intake (FY01)

a. Average Grades of Youth In Region IV



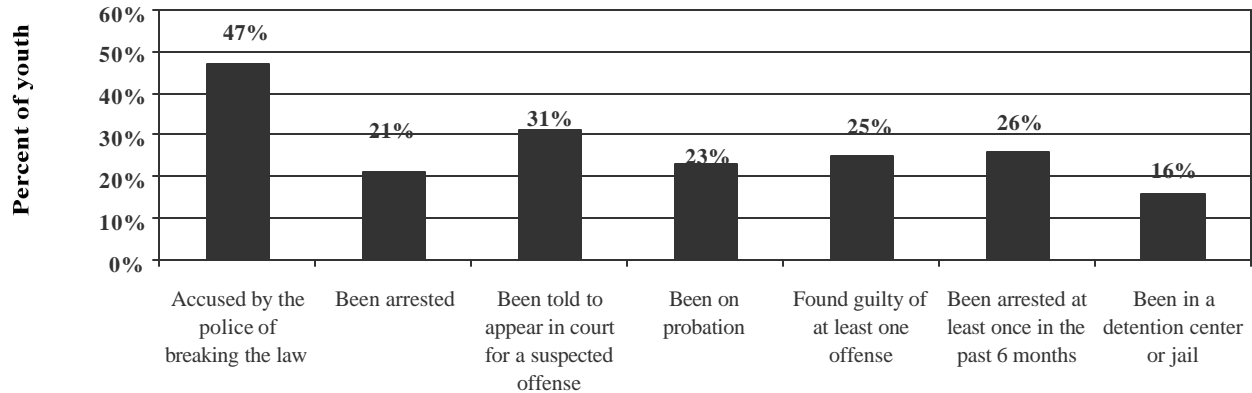
b. Average Grades of Youth in Region II

In Region IV, shown at left, almost half of youth had "C"- average grades and approximately 30% had grades of "D" or lower. In Region II, educational attainment was also assessed, shown on the right. During FY01, 44% of the youth in the program attained "B"-average grades. Grades of "C" or lower were obtained by another 28% of the youth.

Delinquency

Region III also gathered information on the delinquency behavior at intake of some participating youth in the PP program by responses on the Delinquency and Substance Use Questionnaire for youth aged 11 and older.

Figure 8. Region III Youth Delinquency Information (FY01)

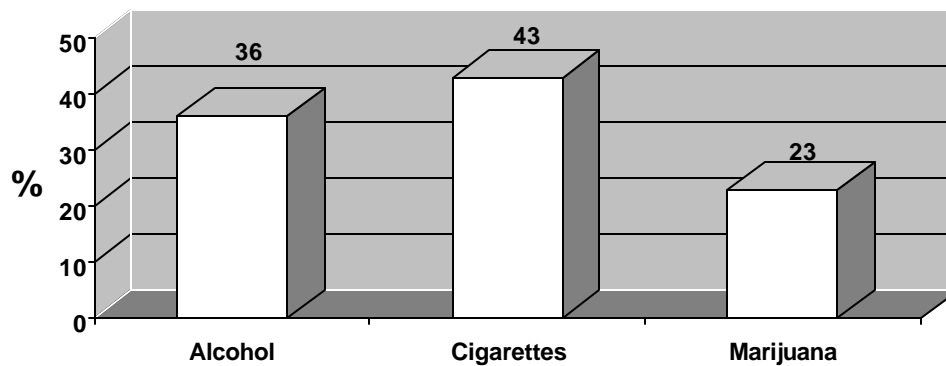


Region II also looked at delinquency information finding that 24% of youth in the program had been found guilty of at least one offense. Twelve percent had been on probation at least once and 4% (1 respondent) had been in a detention center.

Substance Use

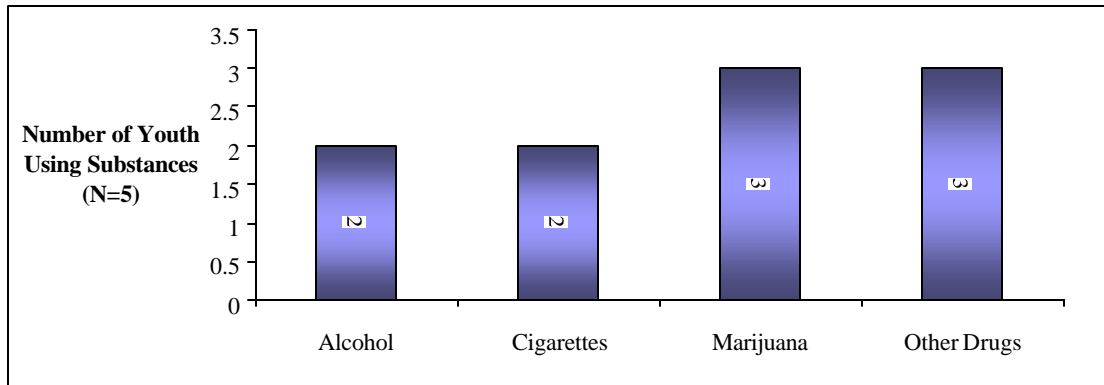
Region III obtained substance use information from 102 youth aged 11 or older at intake using the Delinquency and Substance Use Questionnaire.

Figure 9. Percentage of Youth at Intake Reporting at Least One-Time Substance Use of Alcohol, Cigarettes, or Marijuana at Intake



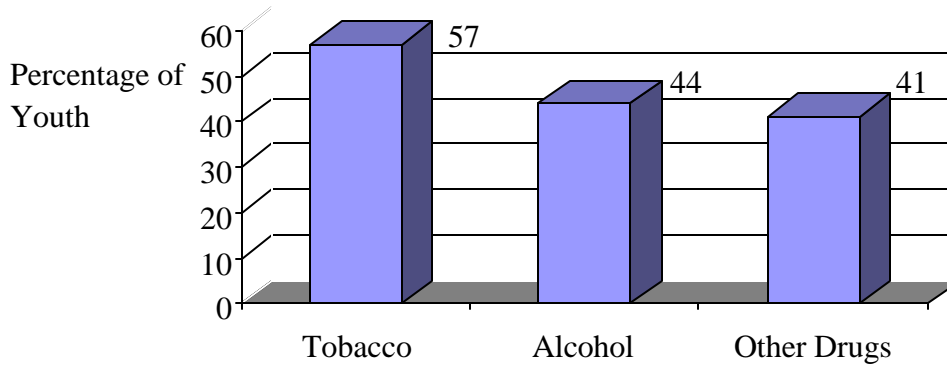
In Region II, substance use and abuse information was gathered. Figure 10 shows the number of youth who have used or abused different substances. This data is based on the five respondents who use or abuse substances and not all of the youth in the program. Of the five respondents who use or abuse substances, over half had used marijuana and other drugs. Nearly half used alcohol or smoked cigarettes.

Figure 10. Substances Used by Youth in Region II Who Abuse Substances (N=5)



In Region IV, 57% of youth in the program use or abuse tobacco, 44% use or abuse alcohol, and 41% use or abuse other drugs.

Figure 11. Percentage of Youth in Region IV Who Use/Abuse Substances



Child and Adolescent Functional Assessment Scale (CAFAS)

Children and youth entering the program have serious functional limitations as indicated by the Child and Adolescent Functional Assessment Scale (CAFAS). The higher the CAFAS score, the more serious the functional limitations. The CAFAS is scored on a 5-Scale or an 8-Scale scoring system. In order to be eligible for the program, youth should score higher than a 50 on the 8-Scale or a 40 on the 5-Scale. Generally, scores relate to the following intervention guidelines:

<u>8-Scale</u>	<u>5-Scale</u>	<u>Intervention</u>
0	0	No dysfunction. Preventive intervention may be desirable if child is at known risk.
10	10	Youth may benefit from some level of intervention or prevention efforts.
20-40	20-30	Youth can likely be treated on an outpatient basis provided the youth does not have any of the risk behaviors listed.
50-90	40-60	Youth may need services beyond weekly outpatient visits, but will likely not need residential treatment unless alternatives are not available. If risk factors are demonstrated, more intensive services may be needed.
100-130	70-80	Youth may need an intensive therapeutic program such as wraparound or residential treatment
140+	90+	Restrictive or supervised living situation may be needed depending on community resources and youth's risk factors

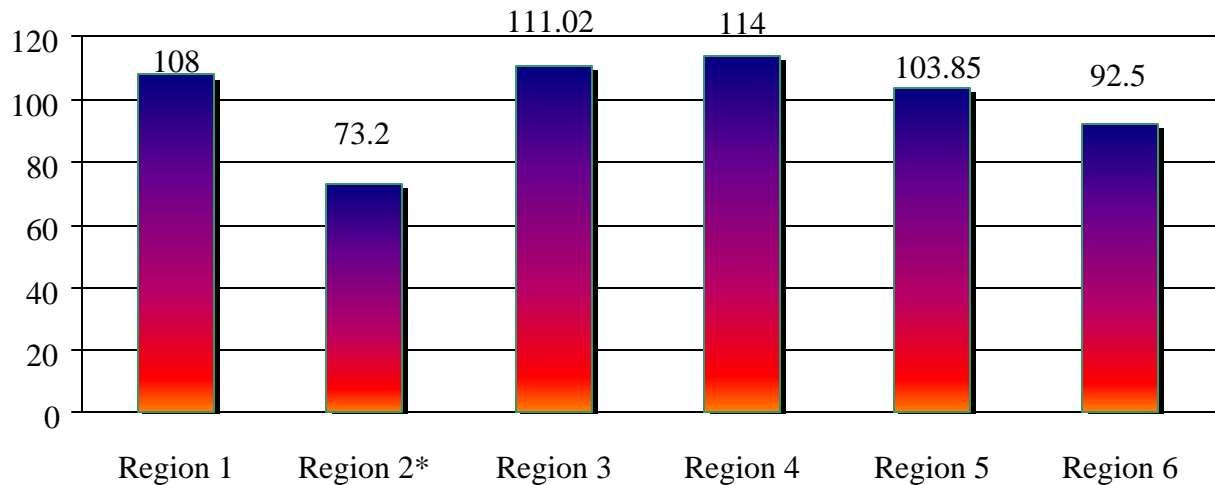
To assess the degree of functional impairment in children enrolled in the Professional Partner Program in comparison to other populations, a random sample of youth in 1) the Region III Professional Partner Program, 2) the Youth Rehabilitation and Treatment Program at Kearney, 3) a Group Home II program, and 4) an agency-based foster care program. The data indicate that while youth in the Professional Partner Program do not have the same level of dysfunction as youth in the group home II and YRTC, the average score is in the range of children frequently placed in residential treatment.

Table 5. Average 8-Scale CAFAS Scores by Living Situation

Living Situation	Number in sample	Avg. CAFAS Score
Home with Professional Partners	27	100.74
YRTC	37	118.73
Group Home II	39	118.20
Agency-Based Foster Care	47	85.10

The Average CAFAS Scores at intake for Regions 1,3,4,5, and 6 based on the 8-scale CAFAS is 105.87. Scores from 100-130 indicate that the youth may need an intensive therapeutic program such as wraparound or residential treatment.

Figure 14. Average CAFAS Scores at Intake for Youth Across All Regions



*Region 2 uses the 5-scale CAFAS and intake average was 73.2.

WHAT SERVICES ARE THEY RECEIVING?.....

At the heart of the Professional Partner Program is the wraparound process. Professional Partners are committed to coordinating a variety of services that will best meet the needs of the youth and family they are serving using flexible funding and community resources. Regions vary in the types of services and supports that are provided for youth and families due to the individual needs of their participants. Table 6 below indicates the most common services by percentage of service costs for each region.

Table 6. FY01 Wraparound Costs: Percentage of Total Costs by Primary Service Categories and Region**

	Region I	Region II	Region III*	Region IV	Region V	Region VI
Mentoring Services	39%	22%	22%	12%	27%	16%
Supportive Services	10%	12%	4%	42%	20%	35%
Individual Therapy	-	5%	3%	8%	19%	10%
Family Therapy	-	<1%	<1%	13%	19%	16%
Recreational Services	16%	8%	<1%	4%	<1%	11%
Tutoring	2%	26%	<1%	7%	1%	1%
Transportation	9%	3%	<1%	3%	4%	<1%
Health Services	<1%	7%	2%	1%	<1%	-
Intensive Family Preservation	-	<1%	-	<1%	5%	-

*A majority of the costs in Region III go towards Multisystemic Therapy (61%). MST was not included here as a primary service category as it is only used by Region III.

**Percentages do not equal 100% as only the primary service categories are listed here.

Figure 12 below shows the distribution of spending for services and supports across all regions during FY01. Overall, the regions reported spending 22% on Mentoring Services, a large percentage of total funds. The use of this service has increased from FY00 (17%) and FY99 (9%). Individual Therapy (8%) and Family Therapy (6%) accounted for a significant expenditure across regions. Supportive Services (15%) was another significant expenditure across regions. Multisystemic Therapy (MST) accounted for 26% of total expenditures, but this is not descriptive across regions as MST is used exclusively in Region III.

In addition to the services indicated here, youth and their families in the Professional Partner Program also receive services through their communities, schools, or other programs free of charge. These services are often coordinated by the Professional Partner and provide substantial support for participants, however they would not be reflected in the total service expenditures.

Figure 12. FY 2001 Wraparound Costs: All Regions

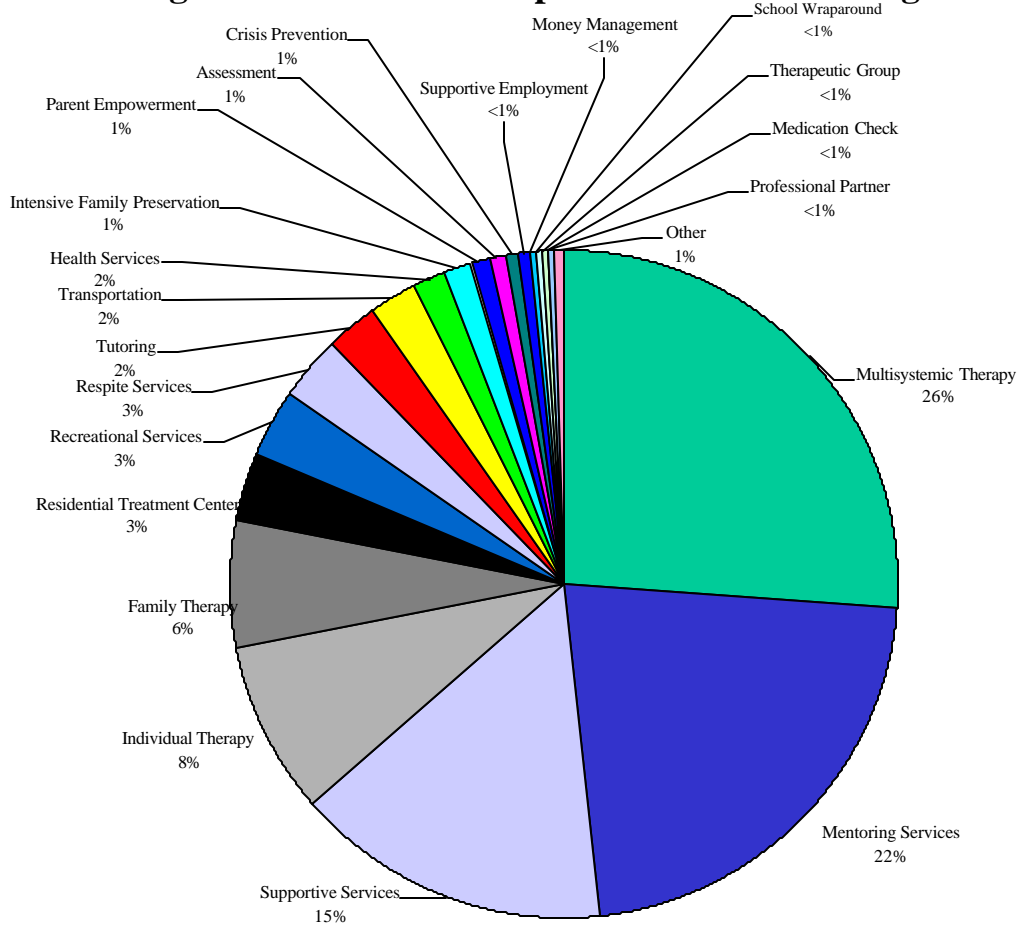
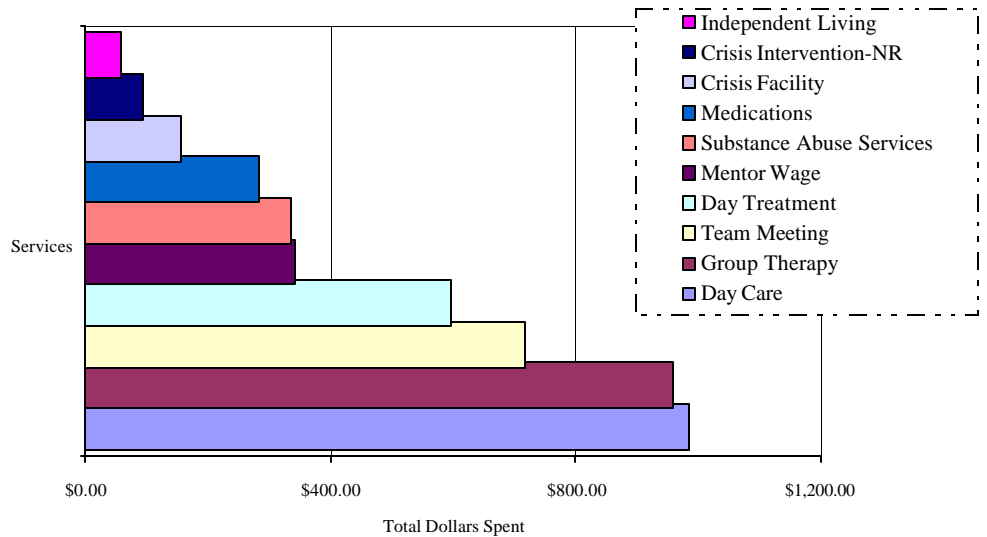


Figure 12b. Other Expenses (1% of Total Costs)

According to Figure 12 above, one percent of the total expenditures were categorized as “other.” Figure 12b at right shows the service categories found within that group. Less than \$1,000 was spent during FY2000 for each of these services.



AT WHAT COST?.....

Total funding for the Professional Partner Program has increased over the last five years. The sources of funding have also diversified, as shown in Table 7.

Table 7. Sources of Funding per Fiscal Year

Source	FY96	FY97	FY98	FY99	FY00	FY01	FY02 (est.)
State/Federal Block Grant	\$1,212,500	\$1,212,500	\$1,889,000	\$1,889,000	\$1,889,000	\$1,973,400	\$2,205,255
Protection & Safety				\$200,000	\$200,000	\$200,000	\$5,353,310
CMHS Child MH Grant			\$485,000	\$485,000	\$1,640,000	\$2,402,980	\$1,936,886
Total	\$1,212,000	\$1,212,500	\$2,374,000	\$2,574,000	\$3,729,000	\$4,576,380	\$9,495,451

The average cost of serving a child in the Professional Partner Program is \$7,627.00 annually. The average cost per child served by region is shown in Table 8.

Table 8. Annualized Cost Per Child By Region for FY01

Region	Cost
I	\$6,690.29
II	\$8,354.50
III	\$8,062.30*
IV	\$7,307.54
V	\$9,272.49**
VI	\$6,054.42

*PPII and OJS figures not included

**OJS figures not included

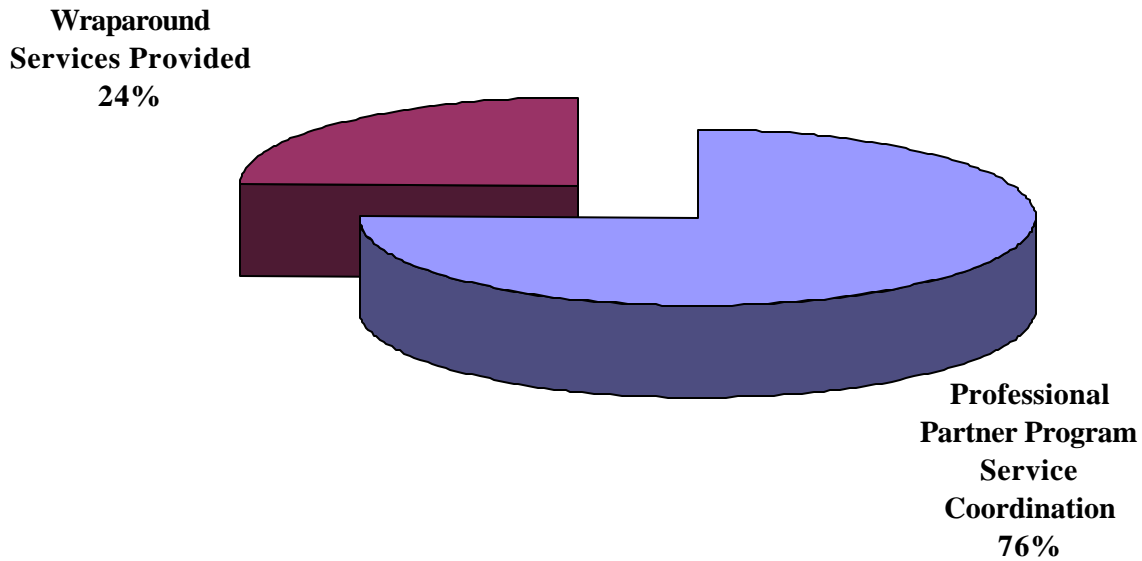
Caring for a youth in out-of-home is very costly. Table 9 identifies the annual cost of placements compared to wraparound costs. One of the main goals of the Professional Partner program is to prevent out-of-home placements. Serving children and families through the wraparound process can save Nebraskans the cost of long-term residential care. While a Group Home II costs \$70,448 a year, the wraparound annual cost is only \$8,376.

Table 9. Annualized Costs of Care by Placement

<i>Placement</i>	<i>Cost per Year</i>
Group Home II	\$70,448.80
Agency Based FC	\$22,812.50
Kearney YRTC	\$24,758.00
Hastings D/A	\$117,073.75*
Professional Partner Program	\$8,376.00

*This figure is based on a per diem rate of \$320.75. The average length of stay in the Adolescent program at Hastings is 90 days.

**Figure 13. FY 2001 Expenditures
All Regions**



The majority of the costs for the Professional Partner Program are related to the service coordination component (76%; i.e., salary, training, office, equipment, etc.) with the rest for service delivery (24%; i.e., services provided, see page 42).

As noted above, many services and supports coordinated by the Professional Partner Program are free of charge and therefore would not be reflected in the total wraparound expenditures.

WHAT ARE THE OUTCOMES?

As some Regions participate in the Federal Children's Mental Health Grants or have collected data beyond the minimum required, each Program varies in the types and amounts of outcome data collected.

ARE CHILDREN AND FAMILIES SATISFIED WITH SERVICES?.....

One of the key outcome indicators is client satisfaction. The Professional Partner Program distributes Satisfaction Surveys biannually and at discharge to youths, parents, team members, and Professional Partners to gauge satisfaction with the Program and perceptions of the services received. Presented here is a sample of the questions actually included on the Satisfaction Survey. The actual questionnaire is based on a version of the Wraparound Fidelity Index designed by John D. Burchard, Ph.D. at the University of Vermont. The following data are based on surveys from Regions I, II, IV, V*, and VI only. Data for Region III is presented in the Appendix: Data Presentation.

*Region V reports are from the May Data collection only.

Youth Satisfaction

Total reports received per region:

Region 1	4
Region 2	20
Region 4	39
Region 5	58
Region 6	21

1. How are you doing?

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Much Better	25	50	25.6	33.3	28.6	34.5
Better	50	40	34.1	42.1	38.1	44.86
About the Same	25	10	7.7	22.8	14.3	19.76
Worse			2.6			.52
Much Worse				1.8		.36

2. How is your family doing?

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Much Better	25	25	33.3	26.3	19	25.89
Better	50	70	41	47.4	57	53.68
About the Same	25	5	20.5	22.8	23.8	19.42
Worse			5			1
Much Worse						

3. *How happy are you with the progress you've made?*

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Very Happy	25	30	30.8	26.3	14.3	25.28
Happy	50	55	43.6	50.9	47.6	49.42
Happy, but hoping for more	25	15	23.1	19.3	33.3	23.14
Unhappy			2.6	1.8	4.8	1.84
Very Unhappy				1.8		.36

Family Satisfaction

Total reports received per region:

Region 1	9
Region 2	36
Region 4	58
Region 5	68
Region 6	46

1. *How is your child doing?*

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Much Better	44.4	61.1	22.4	33.8	30.4	38.42
Better	55.6	22.2	56.9	41.2	43.4	43.86
About the Same		16.7	20.7	20.6	21.7	15.94
Worse				4.4	4.3	1.74
Much Worse						

2. *How is your family doing?*

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Much Better	22.2	36.1	20.7	27.9	26.1	26.6
Better	77.7	61.1	60.3	42.2	50	58.26
About the Same		2.7	17.2	26.5	21.7	13.62
Worse			1.7	3.6	2.2	1.5
Much Worse						

3. *How happy are you with the progress made by your child/family?*

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Very Happy	55.5	47.2	22.4	19.1	24	33.94
Happy	33.3	16.7	24.1	23.5	24	25.66
Happy, but hoping for more	11.1	33.3	50	57.4	20	39.4
Unhappy		2.8			2.2	1
Very Unhappy						

4. *Is your child a member of the team?*

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Yes	66.6	91.7	94.8	75.4	73.9	80.48
Sometimes	33.3		1.7	13.8	8.7	4.84
No		8.3	3.4	10.8	17.4	7.82

Team Member Satisfaction

Total reports received per region:

Region 1	9
Region 2	152
Region 4	66
Region 5	163
Region 6	114

1. *How is the youth doing?*

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Much Better	44.4	30.3	9.1	21.9	16.6	24.5
Better	44.4	49.3	62.1	45.6	38.6	48
About the Same		15.1	18.2	18.8	36.0	17.62
Worse	22.2	2.6	9.1	11.9	6.14	10.4
Much Worse		0.1	1.5	1.9		0.7

2. *How is the family doing?*

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Much Better	16.65	24.3	6.1	16.1	12.3	15.1
Better	50.0	50.7	60.1	41.9	50.9	50.7
About the Same	16.65	22.4	30	31	33.3	26.4
Worse	16.65	1.3	3	10.3	1.75	6.6
Much Worse		.65		.6		.25

3. *How happy are you with the progress made by the youth/family?*

	Region 1	Region 2	Region 4	Region 5	Region 6	Total
Very Happy	44.4	26.9	6.2	17.5	10.5	21.1
Happy		31.5	29.15	16.3	23.8	20.15
Happy, but hoping for more	44.4	33.5	49.25	51.9	50.9	45.9
Unhappy	11.1	1.3	13.9	13.8	14.8	10.9
Very Unhappy		6.6	1.5	.6		1.7

FUNCTIONAL IMPROVEMENT.....

Another key outcome measure concerns changes in the functioning of the child or adolescent as a result of services. Data is available for FY01 from all regions using the Child and Adolescent Functional Assessment Scale (CAFAS). The 8-scale CAFAS measures functional impairments on eight domains:

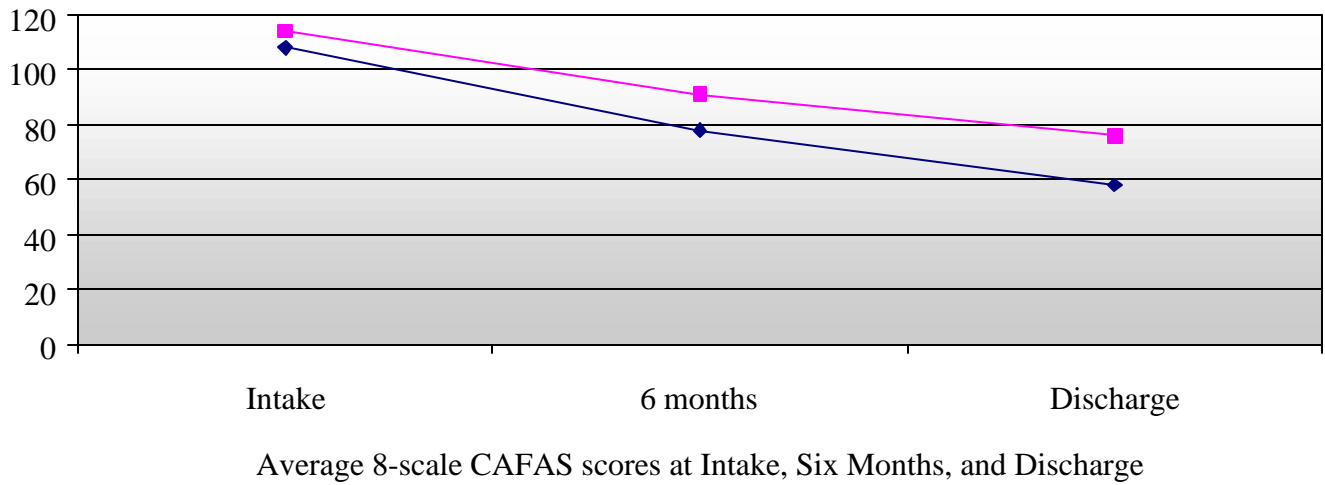
- school role performance
- home role performance
- community role performance
- behaviors towards others
- moods/self-harm & emotions
- self-harmful behavior
- substance use
- thinking

The 5-scale CAFAS (used by Region II) measures functional impairments on five domains:

- role performance
- behavior towards others
- moods
- substance use
- thinking

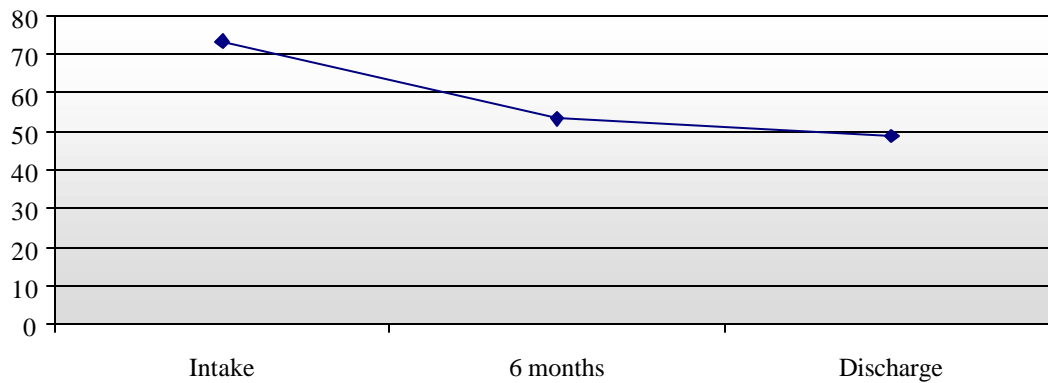
Figure 15 below indicates that functioning improved substantially (CAFAS scores are lower) in each region from intake to six months and from intake to discharge. For Region I, the average CAFAS score at intake was 108. After 6 months, the average score decreased by more than 30 points to 78. At the time of discharge, this score decreased to 58, for a total change of 50 points from intake to discharge. Region IV saw a drop of more than 23 points in their average CAFAS scores after the first six months youth were served. At discharge, scores had gone from 114 to 76, a decrease of 38 points. The intake scores on average were above the level considered to require intensive residential or wraparound intervention, while the six months scores were in a range that for which less intensive, outpatient services might be recommended. It should be noted that discharge average CAFAS scores represent an average overall, so this score could be affected by one or few youth who experienced significant improvement.

Figure 15. Regions I and IV: Average 8-scale CAFAS Scores



A trend similar to that of Regions I and IV above can be found in Region II as shown in Figure 16. Using the 5-scale CAFAS, Intake scores decreased significantly from 73.20 to 53.20 at six months. At discharge, a mean score of 48.75 was obtained indicating a total improvement of 24.45 points by youth from intake to discharge from the program.

Figure 16: Region II: Average 5-Scale CAFAS Scores



Region III provided data on the patterns of average scores on each of the CAFAS domains of functioning. Interestingly, the pattern remained about the same over the six months, twelve month, and eighteen month periods but the average scores decreased in each domain. Figures 17a,b, and c demonstrate improved functioning from intake after involvement with the program. At 18 months (Figure 17c), scores remain improved from intake, but do not show significant improvement over 6- or 12- month involvement in the program. This leveling off in improvement may be attributed to youth with more significant and persistent problems having a longer length of stay in the program.

Figure 17a. Region III CAFAS Domains at Intake and Six Months (FY01)

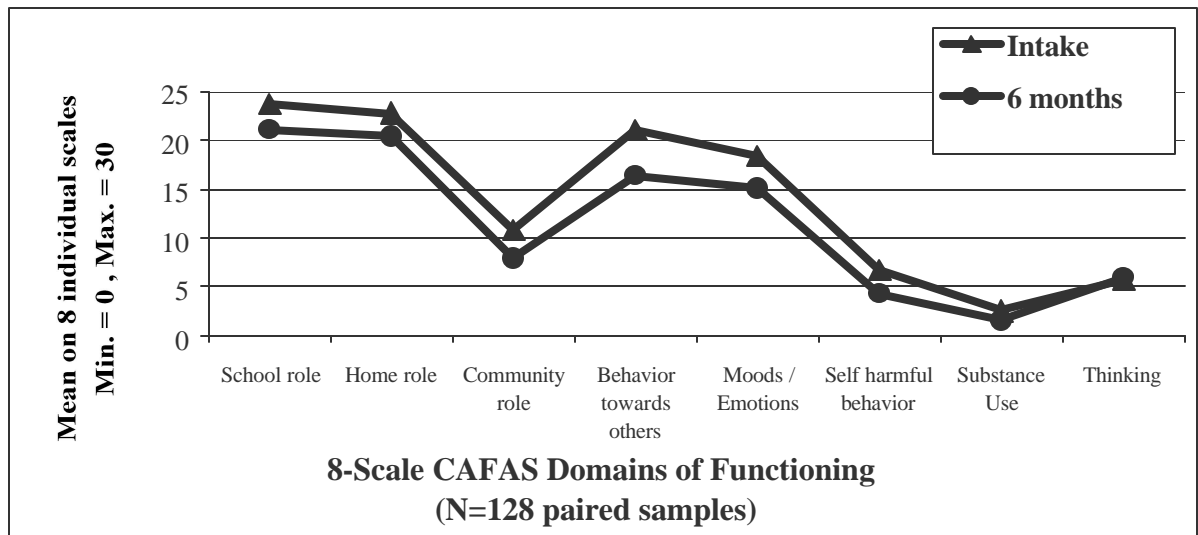


Figure 17b. Region III CAFAS Domains at Intake and Twelve Months (FY01)

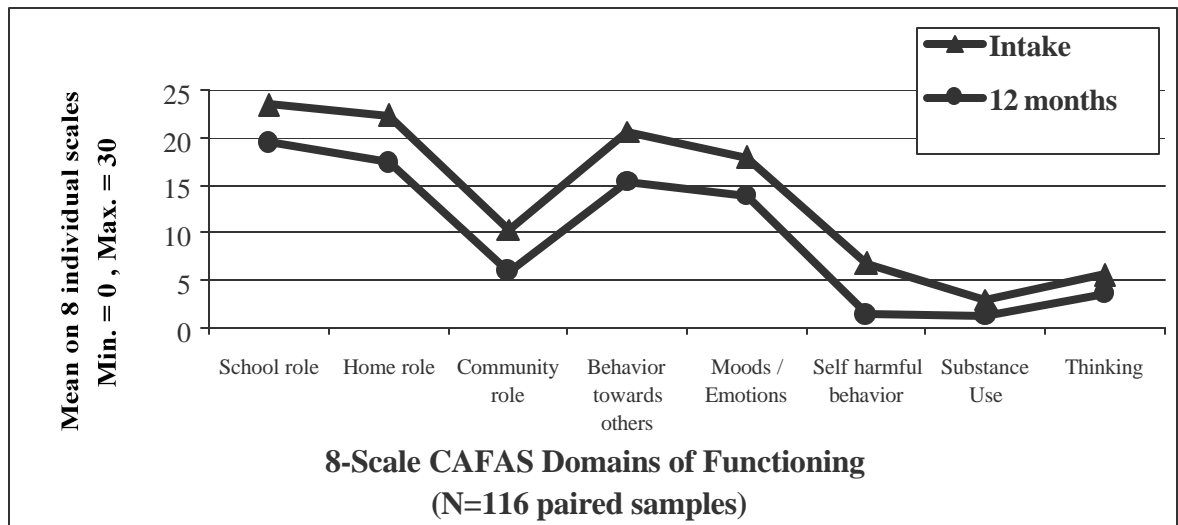
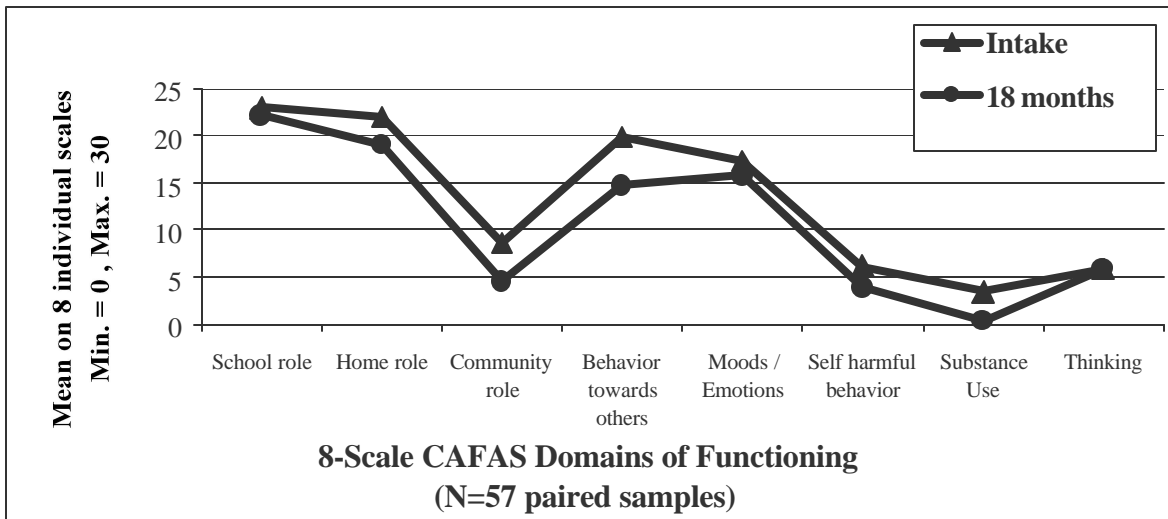
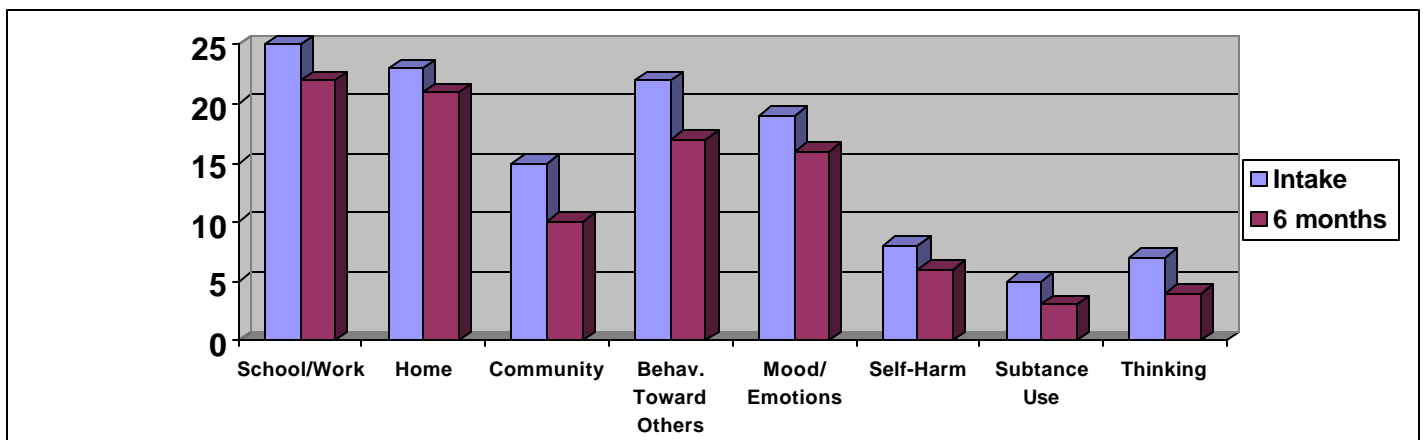


Figure 17c. Region III CAFAS Domains at Intake and Eighteen Months (FY01)



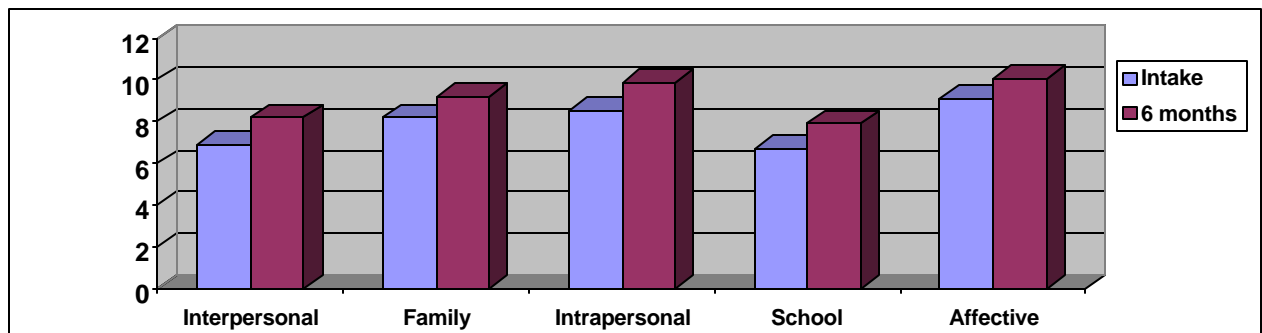
Families First and Foremost (for more information see page 16) also used CAFAS scores to assess functioning across eight domains. A trend towards improved functioning is identifiable from this data.

Figure 18. Families First & Foremost Average CAFAS Scores



The Families First and Foremost program also uses the Behavioral and Emotional Rating Scale (BERS) to assess the strengths of youth in five domains. As Figure 19 shows, there was improvement in each strength domain after six months (higher scores indicate greater strength).

Figure 19. Families First and Foremost: Behavioral and Emotional Rating Scale

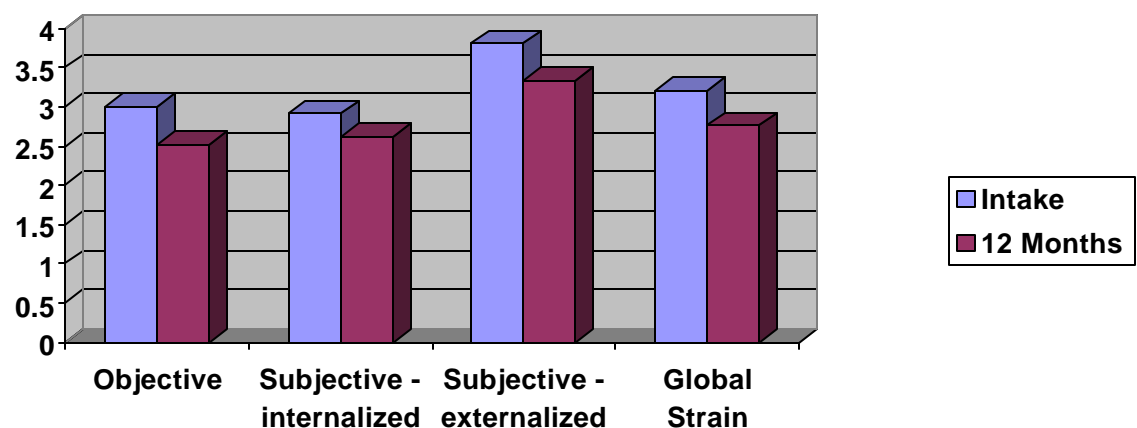


The Caregiver Strain Questionnaire (CGSQ) measures the extent to which caregivers of youth experience additional difficulties, strain, and negative effects as a result of their caregiving responsibilities. Scores range from 1 to 5 with higher scores indicating greater strain. Four scales result from this inventory:

- *Objective Strain* – extent to which observable negative events related to the youth's disorder have been a problem for the family
- *Subjective Strain (externalized)* – relates to the negative feelings about the youth such as anger, resentment, or embarrassment
- *Subjective Strain (internalized)* – refers to the negative feelings that the caregiver experiences such as worry, guilt, or fatigue
- *Global Strain* – indication of the total impact on the family

Region III collected information using the CGSQ. The scores obtained indicate a general trend towards less strain on the family after involvement of the youth in the Professional Partner Program. While the improvement in functionality of the youth is one of the goals of the program, it is also important to gauge the impact the youth's involvement in the program may have on the family. Figure 20 below shows decreasing strain of families from intake to 12 months (N=84).

Figure 20. Region III: Average Score of the CGSQ from Intake to 12 Months (N=84)



The Sutter-Eyberg Inventory is a checklist that rates a child's behavior on an intensity score. This inventory also rates a problem score by asking: Is this [behavior] a problem for you? The higher score indicates worse behavior for the youth. Region IV obtained this information during FY00 and the results show that over 15 months the youth's intensity and problem scores both decreased dramatically, indicating that their behavior has improved (See Figures 21 and 22).

Figure 21. Eyberg Intensity Score for Region IV (FY00)

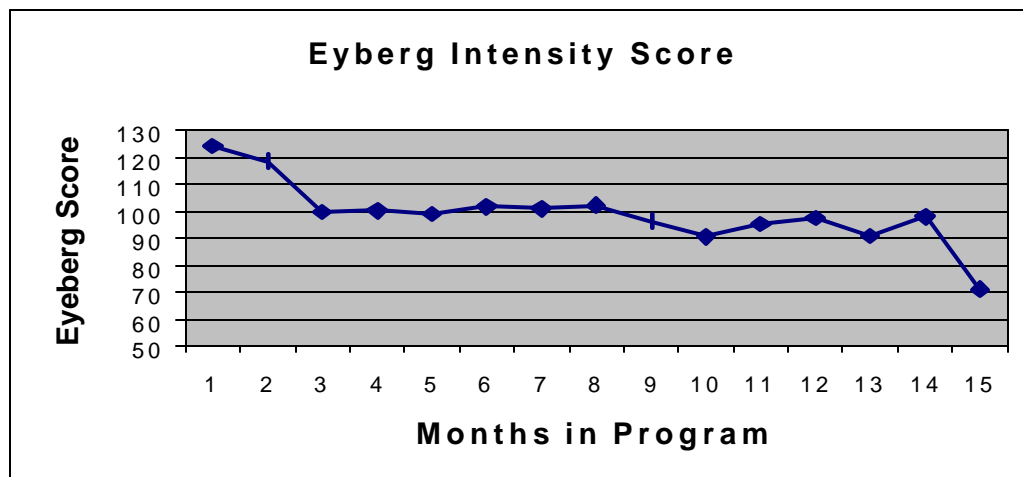
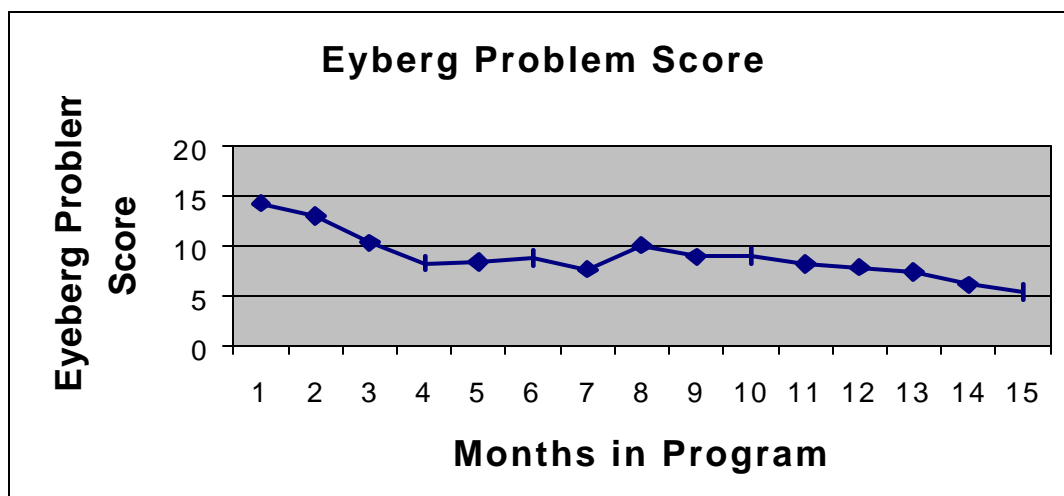
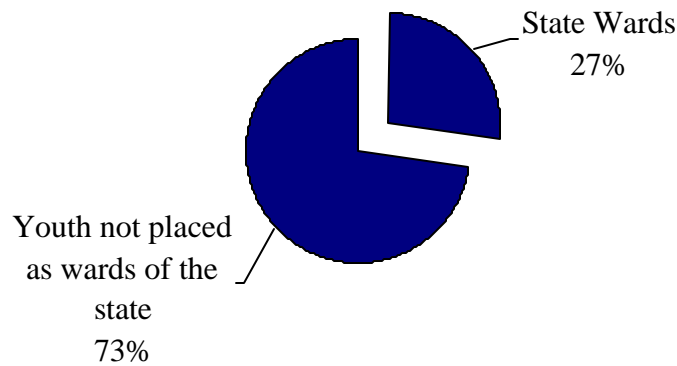


Figure 22. Eyberg Problem Score for Region IV (FY00)



Slightly over one fourth of the youth in the program during FY01 were wards of the state at intake or became state wards during their time in the program.

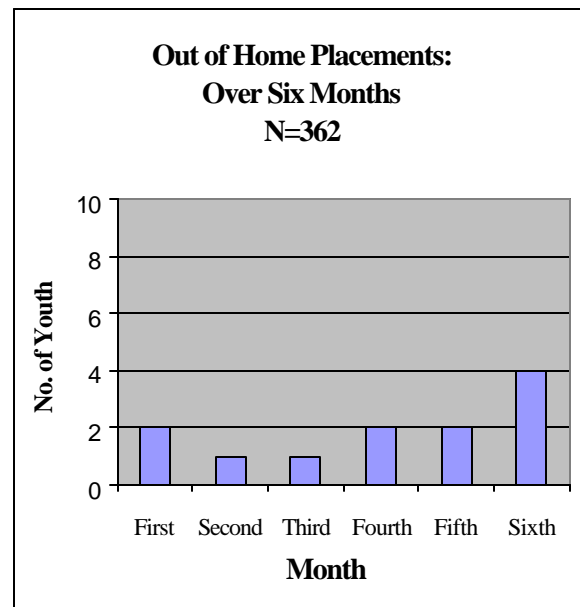
Figure 23. Percentage of Youth Who Entered the Program as State Wards or Became State Wards in FY01



The Professional Partner Program aims to reduce the number of children residing in out-of-home placements. Figure 23, above, demonstrates that approximately one-fourth of the youth in Regions I, II, III, IV, and V entered the program as state wards or became state wards while in the program during FY01. Many children are referred to the program while placed outside the home. The Professional Partner Program works to move youth from these out of home settings back to their homes as often as possible.

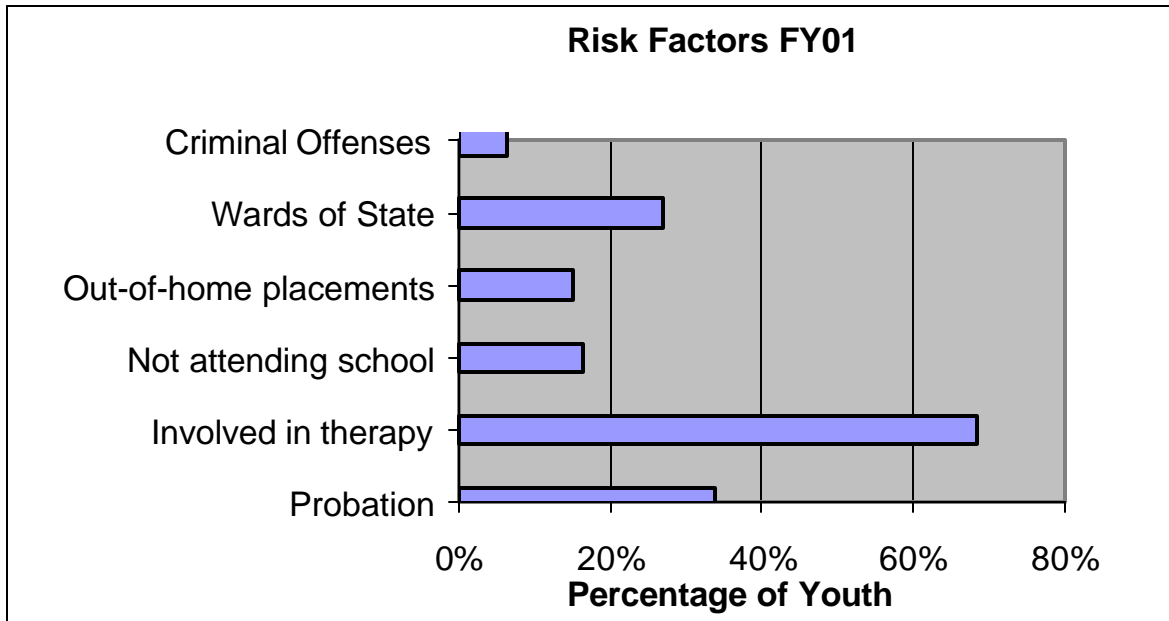
Figure 24 at right depicts the number of youth in Region III during FY99 placed out of the home during six observation periods. The increase in the sixth observation period reflects state wards being accepted as referrals during that period into the program. *Overall only 6% of youth involved with Professional Partner Program were placed out of the home in FY99.* This is defined as youth spending more than 15 days per month in a placement outside of the home.

Figure 24. Out of Home Placements (Region III, FY99)



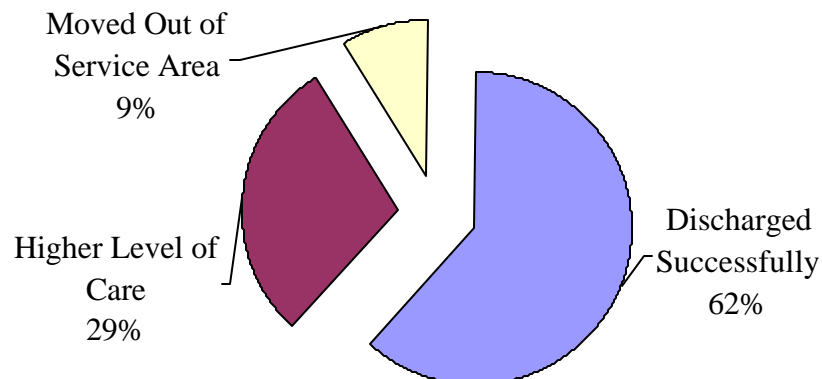
Risk Factors

Figure 27 below looks at the average risk factors for all youth over fiscal year 2001; 68.4% were involved in therapy, 16.5% had not attended school at some point during the year; 15% were in out-of-home placements at some time; 27% were state wards; 6.3% had committed criminal offenses and 33.8% were on probation. Future reports will indicate how the percentages of these risk factors change over the course of involvement with the program.



Region IV reported that 62% of youth in the program were discharged successfully. Twenty-nine percent were discharged to a higher level of care. The remaining 9% of youth were discharged after moving out of the service area.

Figure 28. Region IV: Outcomes Upon Discharge From Services



DATA SUMMARY

A major component of the Professional Partner Program is the use of measurable outcomes to assess the differences being made in the youth and families participating in the wraparound process. For several years the Professional Partner Program has been collecting data that shows improvement in the lives of the at-risk youth receiving these services. The CAFAS scores across regions consistently indicate that the youth are functioning better in many different areas of their lives, including improved performance at school, at home, in their behavior towards others, in their mental health, and with their substance use. The results from the satisfaction surveys have also been consistently very positive, indicating that the families, team members and youth feel good about their involvement with the Professional Partner Program and believe it is beneficial for the youth and their families. Furthermore, data show that youth show increasing strength across interpersonal, intrapersonal, family, school, and affective domains, as assessed by the Behavioral and Emotional Rating Scale of the Families First and Foremost Program. Decreasing Eyberg scores across 15 months indicate fewer behavioral problems as youth become involved in wraparound services. Involvement in the program also alleviates strain on the family as indicated on the Caregiver Strain Questionnaire. In addition, decreases in out of home placements have been found consistently among the youth served, an important goal of the Professional Partner Program. Overall, these results show that the Professional Partner Program has made a substantial difference in the lives of many Nebraskan families by providing individualized service coordination in the home environment at a fraction of the cost of out of home placements.

A more detailed Data Presentation is available from the Department of Health and Human Services and can be requested by contacting Mark DeKraai.